ROCHDALE BOROUGH
SAFEGUARDING CHILDREN BOARD

This report has been redacted for Legal reasons

The Overview Report of the Serious Case Review in respect of Young People 1,2,3,4,5 & 6

This report has been commissioned and prepared on behalf of **Rochdale Borough Safeguarding Children Board** and is available for publication.

Contents

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GLOSSARY

SUBJECTS

YP1
YP2
YP3
YP4
YP5
YP6

An anonymised list of other family members can be found at the end of this report.

Other Acronyms:

A & E	Accident and Emergency
ACPO	Association of Chief Police Officers
CAF	Common Assessment Framework
CAFCASS	Children and Family Court Advisory and Support Service
CIT	Crisis Intervention Team
CSE	Child Sexual Exploitation
CPS	Crown Prosecution Service
CSC	Children's Social Care
DPP	Director of Public Prosecutions
FWIN	Force Wide Incident Notice (Police record of incident)
GP	General Practitioner
HFU	Homeless Families Unit
HCPC	Health and Care Professions Council
IMPACT	Improving Attendance Co-ordination Team Meeting
IMR	Independent Management Review
LSCB	Local Safeguarding Children's Board
OFSTED	Office for Standards in Education
PCT	Primary Care Trust
PPIU	Police Public Protection Investigation Unit
SARC	Sexual Abuse Referral Centre
SCR	Serious Case Review
SCRSP	Serious Case Review Screening Panel
SEN	Special Educational Needs
TOR	Terms of Reference

nb: Appendix D provides a list of explanations for professional terminology, statutory procedures and processes referred to within the body of the report.

1. INTRODUCTION

This Serious Case Review has been prepared in relation to 6 Young People who were subject to serious and prolonged Child Sexual Exploitation during their teenage years. Of the six young people subject to this review, [redacted] All the young people and their families had significant contact with statutory health and social care services, as well as with the police and a number of non-statutory services

The purpose of the Serious Case Review is to identify whether agencies which provided services to these 6 Young People, acted appropriately and to establish what needs to be learned from their experience, to consider and reappraise practice. The Review will identify wider learning for Rochdale based on the experiences of these young people; however it cannot be and does not attempt to be a comprehensive analysis of Child Sexual Exploitation in Rochdale. Neither is the purpose of this Review to be '*part of any disciplinary inquiry or process relating to individual practitioners*'[1], which clearly remains the responsibility of employing agencies.

1.1 Circumstances that led to this Review

1.1 In December 2010, a major police investigation, Operation Span, was instigated in relation to the sexual exploitation of a number of young people in the Rochdale Borough. Over the following year the Serious Case Review Screening Panel (SCRSP) reviewed the information provided by the police and other agencies in relation to the Operation and the impact on a number of young people. In December 2011 the SCRSP reached the conclusion that the grounds may have been reached to undertake one or more Serious Case Reviews.

1.2 However, at this stage the SCRSP were also of the view that the current SCR model was unlikely to provide the necessary learning for agencies within a suitable timeframe and therefore recommended that an alternative form of review be undertaken. The Chair of the LSCB agreed with the recommendation of the SCRSP and initiated a preliminary Learning event which was followed by a 'Gap Analysis' and a published report[2] prior to any further decisions as to whether one or more Serious Case Reviews should be undertaken.

1.3 Following this preliminary review the Chair of the Board asked the SCRSP to reconsider the need for a Serious Case Review and having done so to identify those cases which would provide the greatest learning. The SCRSP subsequently identified 6 Young People whose

[1] Working Together 2010:234)
[2] RBSCB Sept 2012

experience was considered likely to provide the fullest learning for agencies within Rochdale. The SCRSP recommended to the Chair of the Board that a joint SCR in relation to the 6 young people should be undertaken.

1.4 The decision was formally taken by the Chair of the Board in September 2012 that a Serious Case Review should be undertaken in relation to the young people and one other. As was required at the time, OFSTED and the Department for Education were informed of the decision to undertake a Serious Case Review on 17th September 2012.

1.5 An Independent Chair and an Independent Author for this Overview Report were formally appointed at the end of September 2012 and the Serious Case Review Panel (SCRP) was at that point established to manage the process with representation from the relevant agencies.

1.2 The Terms of Reference of the Review

1.2.1 The Terms of Reference for the Serious Case Review, which fully set out the scope and context of the Review are attached as Appendix A. A summary of the Terms of Reference is as follows:

1.2.2 The Terms of Reference were established by the Serious Case Review Screening Panel in line with the requirements of Working Together 2010[3], which states that a Serious Case Review must:

- Establish what lessons are to be learned from the case about the way in which local practitioners and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- Improve intra and inter agency working and better safeguard and promote the welfare of children

1.2.3 The Terms of Reference highlighted that:

> "The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future. It is essential, to maximise the quality of

[3] HM Govt (2010:234)

learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed."

1.2.4 The Terms of Reference were discussed in some detail in the Serious Case Review Panel as a result of which a number of amendments were suggested and adopted by the Serious Case Review Screening Panel. Whilst this at times undoubtedly caused some confusion and difficulties, particularly for IMR authors who were not directly involved in all the discussions, refining the Terms of Reference was crucial in order to accommodate new information as it arose in the early months.

1.2.5 In addition to the overall Terms of Reference the following Key Lines of Enquiry were identified for specific consideration by the Individual Management Reviews:

Key Lines of Enquiry

1. Recognition

a) Comment on your organisation's ability to recognise child sexual exploitation at an operational level and to proactively intervene to safeguard victims and support their families
b) When did your agency first recognise that child sexual exploitation was happening in these cases; and when did you identify that abuse as organised .What was the agency response following this understanding

2. Intervention

a) Consider and comment on the timeliness and quality of intervention, including early intervention services, offered to the subjects of this review by your agency. This should specifically include consideration of:-

i. CAF process
ii. Teenage pregnancy services
iii. Children missing from home
iv. Children missing from education
v. Learning disability services
vi. Physical disability services
vii. Drug and alcohol support services
viii. Recognition of any grooming and recruitment behaviour of the young people
ix. Any other relevant early intervention issues

b) Consider and comment on the effectiveness and development of your agency's strategic approach to CSE during the period of the review.
c) Consider the effectiveness of any services provided to the subjects in relation to their own children, given the history of CSE. This ToR does not seek to review the services provided to any of the subjects' children directly, but to consider any learning for services regarding the implications of the subjects' experience as they moved into parenthood.
d) What protocols, policies and procedures nationally were in place that would have informed and guided operational staff when undertaking assessments, interventions and escalation of CSE cases locally?
e) Consider and comment on the effectiveness of procedures, risk assessments and individual interventions that were in place within your organisation to ensure that Looked After Children living within the Rochdale Borough receive equity of service. In addition, what procedures are in place within the organisation to respond when a Looked after Child is reported as missing from home?
f) Comment on the level and impact of managerial oversight, control and challenge to case work with regard to child sexual exploitation. (at all levels of your organisation)

3. Diversity

a) Consider how the ethnic and cultural background of both perpetrators and victims of CSE influenced practice and decision making within your organisation; and how the organisation responds to issues of equality and diversity.
b) Did assessment and intervention at an operational level fully reflect consideration of ethnicity, cultural, equality and diversity?

4. Partnership working

a) Consider what barriers existed within the review period to inhibit appropriate information sharing in both inter agency and multi-agency settings and identify the barriers to effective inter-agency and multi-agency working specifically related to child sexual exploitation. Identify any good practice examples of interagency work.
b) **CSC & Police** – comment on the interface between your agencies in determining the operational lead and subsequent actions to safeguard children/young people with consideration to the criminal/safeguarding threshold.

5. Context

a) Identify whether there were lessons available from contemporary serious case reviews which, if learnt, would have better informed practice and decision-making in these cases?

b) Consider, from your agency's perspective, the single and multi-agency reviews that have been completed into CSE within Rochdale, with specific reference to the findings and learning identified relevant to your agency.

6. Overview Author Specific Terms of Reference

Consider national direction and relevant frameworks available to strategic leads and practitioners with regard to child sexual exploitation during the review period.

1.2.6 The Terms of Reference (ToR) identified that the time period for consideration by the Serious Case Review should start at the beginning of 2007, the year in which the Safeguarding Board began work on Child Sexual Exploitation. The ToR would finish at the end of the trial which led to the conviction of 9 men for related offences. Any relevant historical information which was outside of the agreed timeline was required to be included in summary form.

1.2.7 It was recognised that the Terms of Reference were not suitable for the Crown Prosecution Service as it does not provide a direct service to individuals. A series of questions, based on the issues identified with the Terms of Reference was therefore produced in order to enable the CPS to produce a report that reflected the concerns of the SCR panel.

1.2.8 There was considerable debate within the SCR Panel with regard to the timescale of the Review. In particular, Greater Manchester Police suggested their preferred approach which was to identify separate timescales for each of the young people to encapsulate their experience from 10th birthday until their 18th birthday. After considerable discussion the majority view of the SCR Panel was that the timescale should remain as identified but with the requirement for all agencies to provide summary information regarding any significant contact prior to the timescale identified. In reaching this conclusion the SCR Panel was of the view that :

- A longer timescale would be unlikely to provide proportionately increased learning and would be likely to necessitate a longer period for completion of the Review.
- Identifying 6 different timescales would make a complex Review considerably more complex and there could be as much information lost as gained.
- The decision regarding which young people should be the focus of the Review had been taken to ensure a cross section of all the agencies and lead to an understanding of their response at different points in the young people's lives.

This was subsequently formally agreed by the SCR Screening Panel

1.2.9 The Panel reviewed the time period during the SCR process to ensure that it was still considered fit for purpose in the light of emerging information. The Panel remained satisfied that the timescale had been appropriately identified.

1.2.10 The agreed timescale was therefore: **1st January 2007- 31 May 2012**

1.3 Membership of the Review Panel

The Serious Case Review Panel was made up as follows:

Agency or Organisation	Role
Audrey Williamson	Independent Chair
Action for Children	Head of Safeguarding
Barnardo's	Assistant Director Children's Services, Barnardo's (North West)
CAFCASS	Head of Service, Greater Manchester, CAFCASS
Connexions(up to April 2013, when replaced by Positive Steps)	Connexions Service Manager until April 2013 Assistant Director, Early Help and Schools, post April 2013 (commissioner)
Crown Prosecution Service	Crown Prosecutor Head of CPS North West Complex Casework Unit
Early Break	Chief Executive
Early Help and Schools	Assistant Director
Greater Manchester Police	Detective Superintendent, Specialist Protective Services
Greater Manchester Probation Trust	Assistant Chief Executive
Heywood, Middleton and Rochdale CCG	Designated Nurse for Safeguarding, Heywood, Middleton and Rochdale
Heywood, Middleton and Rochdale CCG	Designated Doctor for Safeguarding, Heywood, Middleton and Rochdale
Rochdale Children's Services	Safeguarding Unit Manager
Rochdale Children's Services	Interim Assistant Director
Rochdale Boroughwide Housing	Homelessness Service Manager
Pennine Care NHS Foundation Trust	Acting Head of Safeguarding Children

Pennine Acute Hospital NHS Trust	Head of Safeguarding
Youth Service	Senior Youth Officer
Youth Offending Service	Service Manager

The SCR Chair agreed that occasional substitutions could be made for the named panel members within individual agencies, but there would be an expectation that substitutes would be kept to a minimum, fully briefed and able to contribute fully.

Also in attendance at the Panel meetings were the following:

- Sian Griffiths, Independent Overview Author
- Rochdale Borough Safeguarding Children Board Business Manager
- Rochdale Metropolitan Borough Council Principal Solicitor
- Administrator, Rochdale Borough Safeguarding Children Board
- Advisor from The National Working Group (Tackling Child Sexual Exploitation), a charitable organisation formed from a UK network of practitioners working on Child Sexual Exploitation.

From the outset it had been the intention to include on the Panel a member of the Multi-Faith partnership in Rochdale, but no-one could be identified to undertake this role. A decision was therefore taken to appoint a Special Advisor to the Panel to act as an independent 'critical friend' in relation to issues of race and diversity.

The Special Advisor appointed has significant relevant experience including: employment as a Service Lead for a national mental health charity; employment as a Chaplain in Her Majesty's Prison Service; Chair of a divisional police Independent Advisory Group; Chair of a Registered Charity working with young people and their communities.

Audrey Williamson is the Independent Chair of this Serious Case Review. Ms Williamson qualified as a social worker in 1981 and is registered with the Health and Care Professions Council. Ms Williamson has worked in Social Care in a number of local authorities in the North West and was a senior manager in both children and adult social care services before becoming independent in 2011. Ms Williamson is the Independent Chair of Warrington, Halton, Cheshire West and Chester Safeguarding Children Boards .

Sian Griffiths is the Independent Author of the Overview Report. Ms Griffiths works as an Independent Social Worker. She is not employed by any Local Authority or Agency other than for commissioned pieces of work of an independent nature. Ms Griffiths has been a qualified social worker since 1987, working both in the Probation Service as a practitioner and manager and later as a Family Court Advisor in CAFCASS. Ms Griffiths is registered with the Health and Care Professions Council. She has previously authored Overview Reports for Serious Case Reviews for a number of Safeguarding

Boards and is accredited by SCIE to undertake Learning Together Reviews adopting a systems learning approach.

1.4 Timescale for undertaking the Review

Rochdale Borough Safeguarding Children Board recognised that given the complexity of the Review, in relation to 6 young people over a 6 year period, a timeframe longer than the standard 6 months required by Working Together 2010[4], would be required to complete the Serious Case Review and submit the Overview Report to OFSTED and the Department of Education. A submission date was therefore initially set for October 2013 and the Department of Education informed. The complexity of the Review led to some delay and it was ultimately presented to the Rochdale Safeguarding Children Board on 15th November 2013. The Department of Education was informed of the new date.

1.5 Methodology of the Review

1.5.1 This Serious Case Review was conducted in line with the requirements of Working Together 2010. The Review Panel was aware of the ongoing redrafting of Working Together and the development of a systems model for undertaking SCRs. Both the Independent Chair and Independent Author of the Review had been trained in the SCIE Learning Together model. The possibility of adopting such a methodology was therefore considered, but following clear advice from the Department of Education the Review was undertaken, as required, in line with existing statutory guidelines.

1.5.2 The SCR Panel therefore confirmed that the framework for the Review should be that required by Working Together. However, the underlying principles adopted as far as practicable reflected the Systems learning model as outlined in the recently published Munro Report.[5] In particular IMR authors were encouraged to reflect with practitioners on the context of their decision making at the time, in order to maximize the learning from this review. It was further agreed that in line with developing thinking regarding the most effective means of embedding learning arising out of Serious Case Reviews, this Review would not necessarily produce recommendations to the Board which met the 'SMART' criteria, but recommendations which focused on the most significant challenges for the Board to consider and respond to. The intention being to ensure ownership of the actions resulting from the Review and strive for "*more considered, deeper learning to overcome the perennial obstacles to good practice".*[6]

[4] HM Government (2010) Working Together to Safeguard Children, Chapter 8
[5] Munro (2011)
[6] Brandon et al (Sept 2011:2)

1.5.3 The Panel was also explicit in its view that any early lessons identified during the Review should be responded to in practice without delay where this was possible. Agencies were required to provide the Panel and the Board with updates regarding any early learning during the process including a written update prior to the Overview Report being presented to the Board. Where this was provided it is referenced during Section 6 of the Review.

1.5.4 The Panel requested and received Individual Management Reviews from the following agencies:

- Action for Children
- Barnardo's
- CAFCASS
- Crown Prosecution Service
- Early Break
- Education Welfare Service
- GP Services Rochdale
- Greater Manchester Police
- Pennine Acute Hospital NHS Trust (Community and Mental Health Services)
- Pennine Care NHS Foundation Trust
- Rochdale Boroughwide Housing
- Rochdale Metropolitan Borough Council Children's Social Care (Targeted Services)
- Rochdale Metropolitan Borough Council Children's Social Care (Safeguarding Children Unit)
- Rochdale Connexions Trust
- Schools
- Youth Service
- Youth Offending Team

1.5.5 It had been expected that information regarding the involvement of the Local Authority's Legal Services department with the young people would be contained within the CSC IMR, but this was not the case. Requests were made to CSC for the IMR author to include the information and access to Legal Services files was agreed, but this was not taken up. Therefore a short factual report was requested from Legal Services in relation to their involvement with the young people concerned and this was produced.

1.5.6 Information was sought from the following organisations who confirmed that they had no relevant knowledge of the Young People or their families during the time period identified:

- Community Safety Partnership
- Rochdale Metropolitan Borough Council Adults Social Care

1.5.7 Information was also sought from four Local Authorities who were believed to have relevant contact with one or more of the YPs. Authority A provided some historical information regarding [redacted] and her family. Authority B and Authority C provided short reports in relation to their involvement with [redacted] These authorities have been anonymised to protect the identity of the young people. None of the information provided by these authorities identified the need for an IMR.

1.5.8 A Health Overview Report was commissioned from Heywood, Middleton and Rochdale NHS Clinical Commissioning Group to encompass the IMRs of the NHS providers listed above. The report was authored by the Designated Nurse who was also a member of the Serious Case Review Panel.

1.5.9 The Serious Case Review Panel met on the following dates:

- 6th November 2012 (half day meeting)
- 18th December 2012 (half day meeting)
- 8th February 2013 (half day meeting)
- 21st March 2013 (full day meeting)
- 22nd March 2013 (full day meeting)
- 10th April 2013 (half day meeting)
- 8th May 2013 (half day meeting)
- 11th June 2013 (half day meeting)
- 20th August 2013 (half day meeting)
- 26th September 2013 (half day meeting)
- 9th October 2013 (half day meeting)
- 28th October 2013 (half day meeting)

1.5.10 Two structured meetings were also held on 6th November 2012 and 8th February 2013 to brief and then update IMR authors on their role and identify any process problems. IMR authors were also provided with individual feedback on their reports. Authors had access to ongoing advice and support from Panel members and the Independent Chair and Author. As a result all the IMRs were resubmitted following first drafts and several of the resubmitted IMRs provided a subsequently improved depth of learning.

1.5.11 The Overview Author, alongside publicly available information, was provided with the following internal documents:

- Greater Manchester Police: Operation Span, Peer Review

- Greater Manchester Police: Internal Review of Operation Span, April 2011 (Exec Summary)
- Pennine Care NHS Foundation Trust Crisis Intervention Team Records Review

1.5.12 The Overview Author met with and interviewed:

- Chair of Rochdale Safeguarding Children Board, Nov 2010-Nov 2012
- Named Nurse, Child Protection, (retired) Designated Nurse, Child Protection (retired)
- Jane Booth, current Chair of Rochdale Safeguarding Children Board
- Jim Taylor, current Chief Executive, Rochdale Metropolitan Borough Council

Some written information was also provided by the Assistant Director of Children's Services 2009-2012, in response to specific questions.

1.6 Parallel Processes

1.6.1 Police investigations were ongoing during the period that this report was undertaken, including the possibility that one or more of the young people would as a result become a witness in future court proceedings.

1.6.2 During the course of this Review Greater Manchester Police Professional Standards Branch, overseen by the Independent Police Complaints Commission have been undertaking an internal investigation regarding a number of officers. It is anticipated that this will be completed in late 2013.

1.6.3 Children's CSC have, prior to and during the course of this Review, undertaken a number of internal proceedings in relation both to managers and front line practitioners. The outcome of these proceedings has included disciplinary action and referral to the Health and Care Professions Council (HCPC), the regulatory body for Social Workers.

1.6.4 The Local Authority had commissioned a report by an Independent Consultant which was published in May 2013[7]. The primary purpose of this report was:

[7] Klonowski, May 2013

- To highlight opportunities which the Council and its partners may take to reduce the risks and ensure the safety of children and young people within the borough of Rochdale.
- To review the interactions and supporting processes within the Council departments and between the Council and external agencies.

1.7 Young People's Contribution to the Review

1.7.1 In line with the expectations of Working Together (March 2010) early consideration was given by the panel to seeking a contribution to the Review by the Young People.

1.7.2 The Panel agreed that the 6 Young People's contribution to the Serious Case Review would be sought. The Chair of the Panel wrote to the young people and the Board Business Manager and the Head of the Safeguarding Unit also met with them to explain the SCR process and to ask if they would be willing to contribute to the Serious Case Review. Not all the Young People were willing at that point to confirm if they would take up the opportunity to contribute their views to the Review.

1.7.3 The Independent Chair, Independent Author and Safeguarding Board Business Manager arranged a consultation meeting with the National Working Group Youth Participation Officer. The purpose of the meeting was to consider how best to ensure that they were approached and spoken to appropriately and their needs considered.

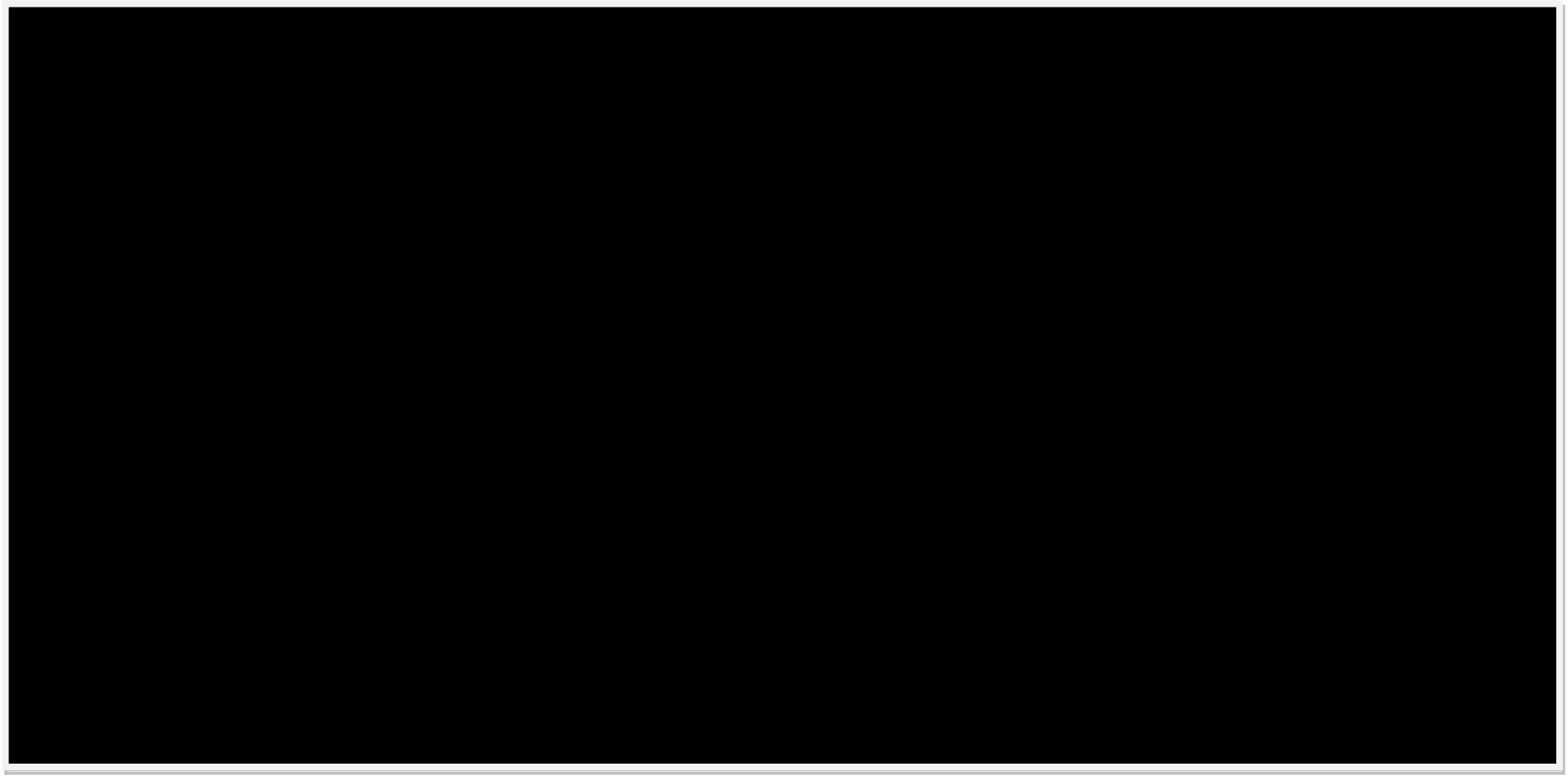
1.7.4 A number of attempts were made by the Independent Chair and the Safeguarding Board Manager to meet with the young people subsequently, including letters, telephone calls and visits to the young people's home addresses. As a result, meetings took place with [redacted] and [redacted] and with [redacted]s parents. The Independent Chair also undertook two substantial telephone conversations with the mother of [redacted]. However,[redacted] chose not to meet with the members of the Review team at this time.

1.7.5 The Serious Case Review Panel considered it particularly important that opportunities to seek the Young People's views should continue to be offered even after the conclusion of the formal process. It was also the Panel's view that the young people should be provided with a meaningful opportunity to have access to the final report and if they wished for support to be provided to enable them to fully understand and respond to the Review, particularly given the level of detail involved. Prior to the conclusion of the Review itself therefore the Independent Chair recorded the agreement of the key agencies that this would be undertaken as long as it was experienced as helpful by the Young People.

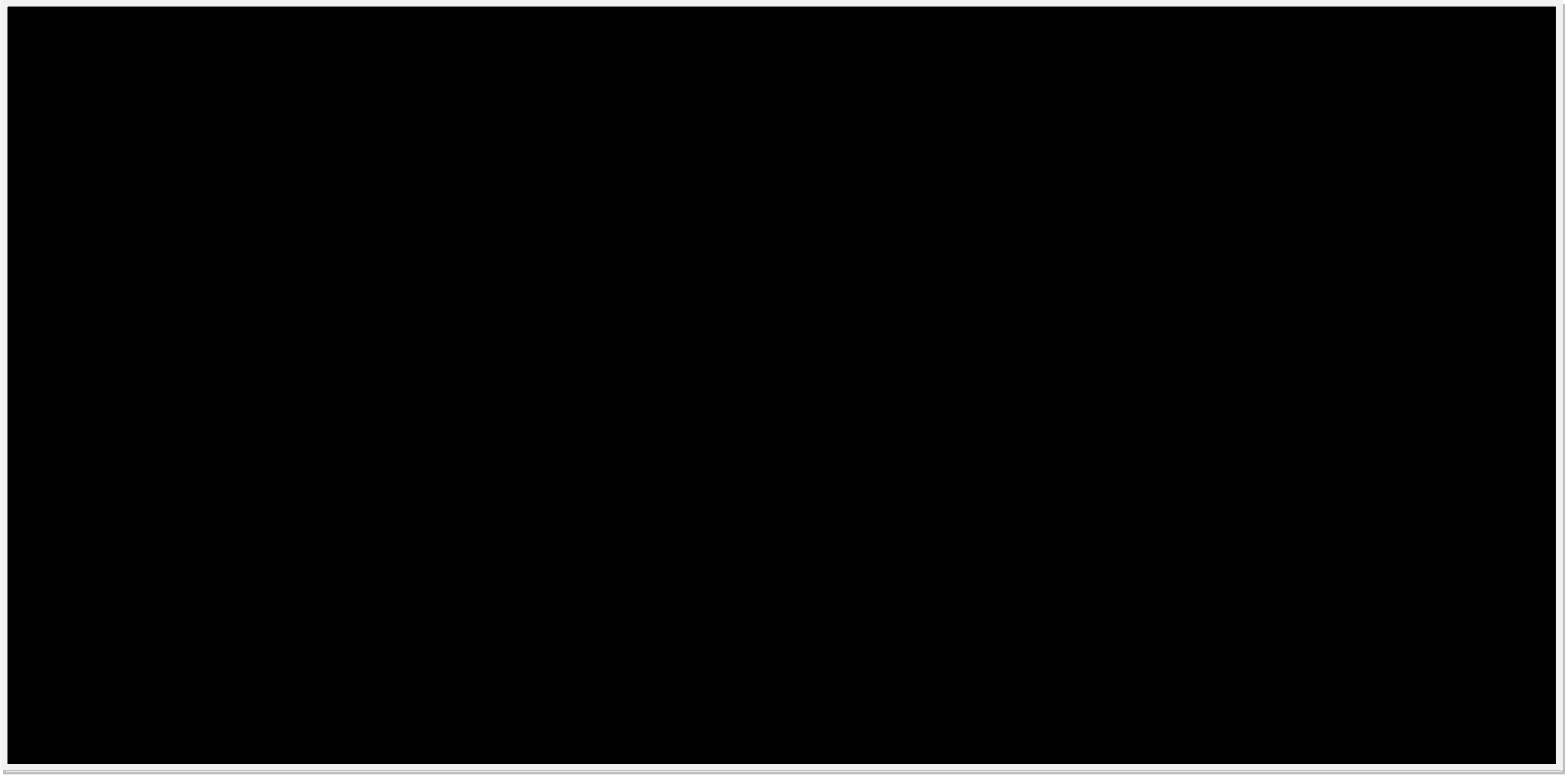
2.1 Genograms

Three Genograms can be found on the following pages in relation to the young people. The information contained represents the end of the period reflected in the timeline. Not all individuals have been included for ease of understanding.

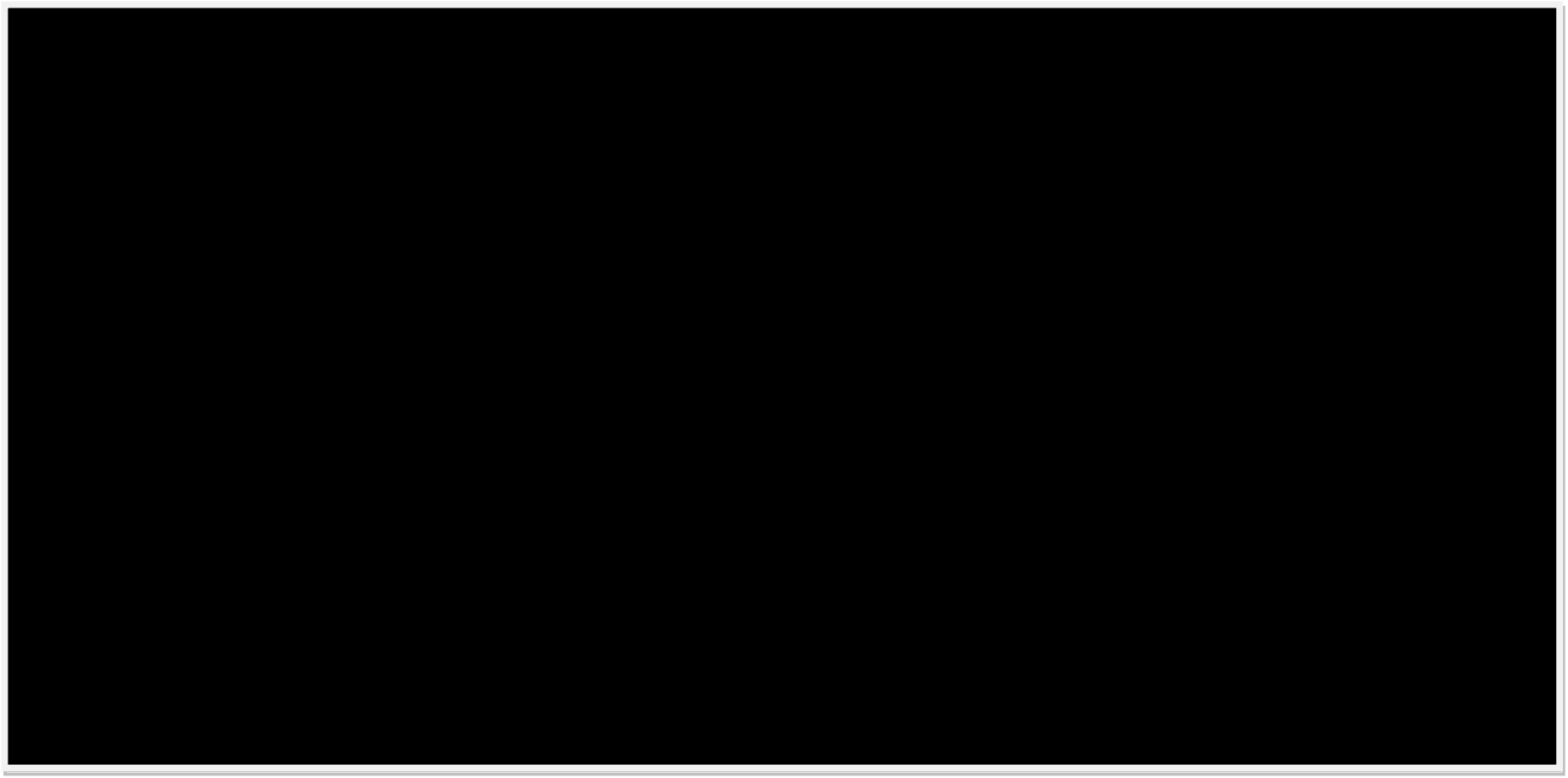
Genogram [redacted]



Genogram [redacted]



Genogram [redacted]



2.2 COMPOSITE CHRONOLOGY OF SIGNIFICANT EVENTS

A full chronology of significant events was prepared to inform this review. Each individual agency provided a chronology as part of their IMR and also provided brief historical information which whilst outside the timeline provided relevant contextual information for the Review.

2.3 RELEVANT ETHNIC, CULTURAL OR OTHER EQUALITIES ISSUES

2.3.1 In line with the requirements of Working Together, IMR authors and the authors of both the Health Overview and this Serious Case Review Overview Report were directed specifically to consider any particular issues of race, culture, language, religious identity or disability which was of significance to the family.

2.3.2 Those agencies who recorded information regarding diversity identified the young people as white British.

2.3.3 Information about the perpetrators' race, culture and ethnic background as understood by the Services involved at the time, is limited. Men are frequently referred to as 'Asian' without specifying what this meant, or indeed why it was considered significant to record it. Within this review the term 'Asian' or other references to race or ethnicity, will be used where it was the term used either by Services or by the subjects and their families. Analysis of the use of this term and what it signifies will be included in Section 4 (Critical Analysis).

2.3.4 Greater Manchester Police identified the men who were convicted at the trial in February 2012 as British Pakistani. Information since provided by the Greater Manchester Probation Trust has established that 1 of the men identified himself as Afghani, 1 as Bangladeshi, 1 as Punjabi and 5 as of Pakistani origin. However another man, AdultD who was separately convicted of sexual activity with a child and sexual assault was White British.

2.3.5 All the young people were brought up in economically impoverished areas of the borough where there was significant intergenerational disadvantage. The 2010 Index of Multiple Deprivation results placed Rochdale borough as the 29th most deprived out of 326 districts in England (DCLG website[8]).

2.3.6 There is only one reference to suggest that religion may have been a significant feature in any of the Young People's lives. This was a comment by [redacted] made to a Connexions Personal Advisor, that her father blamed her for her pregnancy and then had influenced her to have the baby because it was "their religion" There is no further information as to what religion this was or how significant it was to

[8] https://www.gov.uk/government/organisations/department-for-communities-and-local-government

[redacted] No other information regarding the place of religion in the young people's lives has emerged.

2.3.7 [redacted]

2.3.8 [redacted] was assessed as having moderate learning difficulties in [redacted] when assessments were undertaken as part of court proceedings, but no previous reference to this has been identified.

2.3.9 There are various references to [redacted] as having learning difficulties/disability. Information as to the extent of any difficulties is variable [redacted] she was described by the Children's Guardian as having a moderate-significant learning disability making it difficult for her to achieve significant changes to her behaviour. In November of the same year she was referenced in Pennine Acute Health Trust records as having a mild learning disability.

2.3.10 [redacted] was also recorded as having learning difficulties. She had a statement of Special Educational Needs and was identified as 'School Action Plus' due to behavioural difficulties, comprehension and interaction while she was at school. Information from the school also described her mother as having Special Educational Needs, although no further information has been provided. Two other children of the family were noted as 'having Special Educational Needs'.

2.3.11 The terms 'Learning Difficulties', 'Learning Disability' and 'Special Educational Needs' have particular definitions in certain contexts, predominantly in Education or Health policy and procedures. However, they are also often used interchangeably and less precisely which can lead to misunderstanding about what is intended.[9] The terminology of Learning Difficulties and Learning Disabilities is used within the Review as identified within the information provided by agencies, otherwise the wider term Learning Difficulties will be used in the Review.

2.3.12 Little information is recorded about [redacted] health, although there is reference [redacted].

[redacted]s recorded as having serious learning difficulties. She spent some time in an independent school for children with behavioural, emotional and social needs and was subject to a statement of Special Educational Needs. She is also known to have [redacted]

2.3.14 [redacted] was subject to a statement of Special Educational Needs; due it appears primarily to low attendance at school and the consequent

[9] Se Appendix D for more detail.

impact on basic skills including literacy and numeracy. She also suffered from asthma.

2.4 Information provided by the Young People and their families

2.4.1 [redacted] provided the following information and views to the Review:

2.4.2 [redacted] described her family as complicated and said that there were lots of problems in the family relationships before she or [redacted] were subject to the abuse. She believed that the family had needed help from agencies when they were all much younger and said that her mother had asked for help many years ago, but this had not been provided.

[redacted]

[redacted]

[redacted]

2.4.6 [redacted] provided the following information and views:

2.4.7 [redacted]

2.4.8 [redacted] provided the following information:

[redacted]

2.4.15 [redacted] **parents** contributed the following information and views:

2.4.16 [redacted] parents felt that agencies had really failed to work together, to listen to them or to keep them informed. [redacted] father said that he spoke to CIT regularly and had had between 40&50 phone calls with Children's Social Care alerting them to the problems they were having with [redacted] including her uncontrollable drinking, running away and difficult behaviour.

2.4.17 They had been told that CIT had informed CSC that their daughter was being groomed and so they should have done something. They

also understood that the school had been pressuring Children's Social Care to take action. They said that if they had had family who lived away from the area they would have sent their daughter to them in order to get her away from it. But as they did not have anywhere to send her they begged CSC to help them and asked that they remove [redacted]

2.4.18 [redacted] father described being told by Social Workers that his daughter was a child prostitute and was angry that he accepted this because he did not know that it was wrong and feels that Social Workers gave him bad information. He has felt guilty since that because of what he was told he also thought his daughter was a prostitute.

2.4.19 Their experience of the police was that the police officers who attended and who would return their daughter to them were good but that the Police and CSC weren't good in 2008 They felt that things had changed when the new CPS Chief Crown Prosecutor for the North West looked at the case again, which they understood was as a direct result of CIT putting pressure on him. They also felt that the police who took over in 2010 were good and he is still in touch with DC5 who had since left the Police Force.

2.4.20 [redacted] parents said that she had only been friends with [redacted] for about 6-10 weeks before the problems started. They had met her when she came to their house and thought that she was 'OK'. When [redacted] first moved out and went to live with AdultD her father went to meet him and had thought that he was OK and she would be safe there. But then the police would remove her from the house and bring her back. One police officer said he would not let his own daughter stay with that family and the parents also believed that Children's Social Care knew about the family and did not tell him. [redacted] said that in response to what the police officer had told him, he said he would lock his daughter in her room, but the police officer said he could not do that as it would be false imprisonment. [redacted] said that there were no boundaries in Adult D's house, with pornography on the television all the time and very sexual behaviour.

2.4.21 [redacted] parents spoke emotionally about trying to bring their daughter back from AdultD's house, waiting outside in the car for her, not knowing what else to do.

2.4.22 [redacted] parents recognised that [redacted] was also a victim of the abuse, but do not feel able to forgive her for the way she recruited the other girls. He believes that she should have been charged even though she was a victim herself.

2.4.23 They said that sharing information between the agencies was problematic and that the way they responded was not acceptable. [redacted] mother said that sexual exploitation was still going on, but they did feel that agencies' responses had improved and they were more

responsive now. They felt happy about the Social Worker who was now working with them and their grandchild who they feel has tried to put things right.

2.4.24 [redacted] parents believe that she is still suffering from post-traumatic stress disorder. They also felt strongly that the way services responded was because of their attitudes to class "*it's what they expected of our children"*.

2.5 RELEVANT HISTORICAL INFORMATION

Agencies were required to provide a summary of any relevant information known to them prior to the period identified as the focus of this report. The purpose of the information which is summarised in this section is to provide historical background information to better provide a context as to the young people's experience.

Replacement for redacted Section 3

3 INFORMATION KNOWN TO AGENCIES DURING THE TIMESCALE OF THE SCR

As with all SCRs a comprehensive chronology was prepared and detailed the relevant contact episodes between YPs1-6 and each agency. Each IMR and the Health Overview Report included a full detailed chronology and narrative containing all the information regarding the agencies' involvement with each of the young people individually. The detail cannot be published for legal reasons. This section therefore provides a summary of the young people's experience collectively during the period under consideration. Section 4 will critically analyse the detail of events and contacts with agencies.

3.1. YPs1-6 had considerable involvement with a very wide range of services in Rochdale including Children's Social Care(CSC), Health Services; the Police and voluntary organisations. The young people came from three different families. They did not all know each other, but there were some links between them. All of the six young people experienced significant and serious sexual exploitation at some time during the period under consideration by a group of "Asian"[10] men in Rochdale and elsewhere, who they met in takeaways and through contact with taxi firms. The impact for all of the young people has been considerable.

[10] The term Asian is used within this Review where this is the terminology used by the agencies involved with YP7.

[redacted]

3.3. [redacted]. The mother of some of the young people repeatedly raised concerns, for example with the police, about the men they were spending time with and their safety. On a number of occasions allegations which can now be clearly seen as being about sexual exploitation and assault, were made by some of the young women. There was also a significant amount of information that should have alerted agencies to the likelihood that the young women were experiencing some sort of serious abuse, whether or not this was understood at the time to be child sexual exploitation. There was however a pattern of these allegations either not being properly referred to the lead statutory agencies (Police and CSC) or investigations not being effectively concluded when referrals were made.

3.4. A number of the young people [redacted] at an early age and required access to other health services which would be expected to raise concerns about their well-being given their young chronological, emotional and developmental ages. There was repeated information being provided to and between various agencies about the young people being involved in sexual activity with a number of older 'Asian' men. It was also the case that some of the young people were said to be involved in sexual activity with a white man and his sons, with whom they were loosely connected and where they lived for periods of time. Sometimes the information about sexual activity with older men included information about violence or threatening behaviour to the young people. Another feature was a pattern of attendance at Accident and Emergency Departments, frequently in the early hours of the morning, sometimes following injuries or overdoses. Mental health services had some involvement as a result.

3.5. Two of the young people, who were siblings, and became subject to Child Protection Plans for an extended period as a result of the police being given specific information regarding the possible sexual exploitation of a number of young people. This resulted in a lengthy police investigation by detectives in Rochdale, but none of the men

concerned were charged at that time, as a result of the advice of the Crown Prosecution Service. This was due to a significant degree to the CPS view of the young people's credibility as witnesses. This investigation was subsequently re-opened in what was to become known as Operation Span and ultimately led to the prosecution and conviction of a number of men in 2012. Throughout the time the young people were on Child Protection Plans there was information to indicate that they continued to be abused.

3.6. At times the young people were unable to live in their family homes and spent periods living in hostels or supported accommodation. [redacted]

3.2 History of the Criminal Investigation and development of Operation Span

3.2.1 The purpose of this section of the Review is to consider the role played by the Police in the multi-agency response and safeguarding of the 6 young people as a result of their investigations, culminating in Operation Span. It is important to state that it is not its role to detail and analyse the response of the Police primarily from a forensic perspective. This section will provide factual information about actions taken, analysis will be considered in Section 4.

3.2.2 Operation Span was the major police investigation established in late 2010 as a result of a recognition that organised child sexual exploitation was taking place in Rochdale. With hindsight the Police have identified that there was relevant information known to the family of [redacted] as far back as 2002. By 2004 the Police recorded that [redacted] was believed to be having sex with 'Asian' men. There was reference to her '*prostituting*' herself by both family and the Police and this information was referred to the Public Protection Unit, but there is no record of any further response.

3.2.3 Similar information began then to be identified both by the Police and by other agencies in relation to all the young people subject to this Review and has been noted in Sections 2 and Sections 3.1-3.6. Other young people, not subject to this Review, were also being identified in similar terms.

3.2.4 In February 2007 DCI1 from the Rochdale Division had written to the CPS raising concerns about the CPS decision not to prosecute following an allegation of physical and sexual assault against [redacted] in

October 2005 (See Section 2.4.1). In this letter the DC1 identified an awareness of potential child sexual exploitation within Rochdale.

3.2.5 During 2008 and 2009 investigations were undertaken by Rochdale Division CID into the rape and sexual exploitation of a number of young girls, including [redacted]. These investigations arose in part out of the events of August 2008 involving [redacted] as well as incidents involving other young people. The initial investigation centred around two takeaways in the Heywood area of Rochdale in which girls were supplied with food and alcohol and sometimes drugs, in order to procure sexual acts with a number of 'Asian' males.

3.2.6 During these investigations it was also identified that [redacted] had also been exploited by a white man, AdultD, as had [redacted] . There was no known connection between the 'Asian' males and AdultD, the connection instead arising in relation to the victims, not the perpetrators. The crime report written as a consequence by DC6 in August 2008 was the first evidence of an operational police officer, identifying to more senior officers that this appeared to be "*part of a larger scale sexual exploitation case with other potential victims".*

3.2.7 Two men, [redacted] were arrested and interviewed following interviews with [redacted] In July 2009 DS1 submitted a request for advice to the CPS as to whether they should be prosecuted for rape. The case was reviewed by a Senior Crown Prosecutor, CPS4 who sought a second opinion from CPS6 as he was required to do given the allegation. The decision from the CPS was not to prosecute as [redacted] was considered an 'unreliable witness'.

3.2.8 [redacted] had also been arrested [redacted] for causing criminal damage and theft at the takeaway. She was bailed and a file sent to the CPS for authorisation to charge her, but this was refused by the CPS. However in [redacted] CPS was informed by [redacted]'s solicitor that [redacted] had been summonsed for criminal damage. The CPS contacted the police and the charge was subsequently discontinued.

3.2.9 The Police investigation into possible sexual exploitation of young people by both the group of 'Asian' men and by AdultD continued throughout 2009 and was undertaken by Rochdale CID. Video interviews were undertaken with a number of young people, although many of the victims would not engage with the police.

3.2.10 In February 2010, a second investigation was in effect begun, led by DI1, the officer in charge of the Public Protection Investigation Unit in Rochdale Division. The Sunrise team was also now in operation and was based within the PPIU. In April 2010, DI1 sent a Divisional Investigative Assessment report to her line manager, a member of the Senior Leadership Team for the division. The nature of a DIA report being to ensure that any investigation '*which may represent a threat to the division and or the Force, or is too big or too complex for the*

Division to investigate themselves" is formally assessed. In this report DI1 requested additional resources to investigate child sexual exploitation in Rochdale either from within the division or from the wider Force. No extra resources were provided and the report was not submitted to Force Command as would have been required for any consideration of further resources from the wider Force.

3.2.11 In September 2010 the PPIU at Rochdale began the first of a series of interviews [redacted] which took place over a 7 month period. This was effectively a re-documenting and assessing of the allegations made [redacted] in 2008, but now with specialist child protection officers conducting the interviews. During this period AdultD was also re-interviewed following further disclosures [redacted] , however this was not progressed to a charge until August 2011, due to a decision by the Reviewing CPS lawyer to concentrate initially on the larger group of offenders who were subsequently covered by Operation Span.

3.2.12 In December 2010, a Gold meeting[11] took, place chaired by the Assistant Chief Constable, ACC1, the investigation was designated a "*critical incident'*. As a result a dedicated investigation team, Operation Span, was set up and a new Senior Investigating Officer, DSuper1, was appointed. The team was overseen by an Assistant Chief Constable, and moved from the Rochdale Division into a Force Major Incident Team. DSuper1 contacted the CPS lawyer, CPS8, in December asking for a reconsideration of the evidence obtained from the second investigation. CPS8 subsequently wrote to the then Chief Crown Prosecutor for the North West, CCPS1NW, and the then Head of the CPS Complex Casework unit, CPSCCU1 identifying "*widespread child exploitation in the Rochdale Division"* and the need to review previous charging decisions. As a result the case was transferred to the CPS Complex Casework Unit and allocated to CPS2.

3.2.13 An experienced Detective Constable, DC5 was appointed specifically to work with [redacted] as it was recognised that they had very little trust in the police. In February 2011 a decision was made in consultation with the CPS

[redacted]

3.2.14 In June 2011 the Chief Crown Prosecutor for the North West overturned the decision taken by CPS4 in July 2009 regarding the charging of [redacted] The two men were prosecuted and convicted at the trial in February 2012.

[11] Gold Meetings are a Police Force Leadership level response to a potentially critical incident.

3.2.15 This investigation led to the trial of 10 men at Liverpool Crown Court in February 2012 and the conviction of 9 of the defendants in May 2012. [redacted] were all identified as victims of these 9 men.

3.2.16 AdultD was also convicted of offences [redacted] following a trial and sentenced to 4 years imprisonment[redacted].

4 CRITICAL ANALYSIS

4.1 Introduction

4.1.1. This analysis is based on the individual Agency contributions to the Review, additional material and meetings with key personnel as identified in the methodology, discussions held within the SCR Panel and the author's own contributions.

4.1.2. IMR authors were required to structure their reports using the Key Lines of Enquiry established within the Terms of Reference as these represented the starting hypotheses. All of the Terms of Reference, including the Key Lines of Enquiry which provided the working hypotheses for consideration within this review have been considered and used as the starting point for this analysis.

4.1.3. This Review, which has considered the experience of 6 young people over a period of more than 5 years, has generated a very significant body of material. The IMRs have analysed the actions of their agencies in considerable, often forensic, detail. The focus of this Overview Report is not to provide a comprehensive analysis of all this information but to summarise the effectiveness and standards of practice and to draw out the key learning both for individual agencies and the multi-agency safeguarding partnership.

4.1.4. IMR authors were specifically asked to ensure that key people were interviewed and that there should be a focus on not simply what had happened, but why people thought practice and processes had either been effective or ineffective and what might have for example affected decision making. A significant number of key personnel have either since left the authority or as a result of internal proceedings not been in a position to be interviewed. This inevitably leads to some gaps in our understanding.

4.1.5. The critical analysis will therefore be structured using a number of significant themes which have emerged, using examples to evidence learning. The themes do not exist in isolation but are inter-related. Information provided outside of the timeline identified for Review (see Section 2.4), is subject to analysis in this section only where it provides significant contextual information, or leads to learning for current practice that would not otherwise be identified. A summary analysis of each agency's involvement with the young people and contribution to this Review is included in Section 6, including details of what actions have been taken to improve services since these events took place.

4.2 Strategic leadership in relation to child sexual exploitation during the time frame

"Effective leadership sets the direction of an organisation, its culture and value system, and ultimately drives the quality and effectiveness of the services provided."[12]

4.2.1. The Overview Report was specifically required to consider the response of agencies to child sexual exploitation in Rochdale during the identified time period, from both an operational and strategic perspective. An analysis of the strategic response by Rochdale Borough Safeguarding Children Board and its relevant partner agencies is fundamental both in its own right but also in order to understand the context within which operational decisions relating to the young people were made at all levels and as a result provide some insight into why those decisions were made. This section will summarise the status of knowledge and policy development prior to and during the time line of this review and consider the strategic Rochdale response within this context.

4.2.2. The exploitation of children for the sexual gratification of adults is far from a new phenomenon, but what is comparatively new is a shift in societal understanding of this phenomenon. As recently as 5 years ago, the sexual exploitation of children was largely defined as child prostitution, by implication a disturbing social evil rather than something that was recognised unequivocally as child abuse. In May 2000 Supplementary Guidance to Working Together[13], was published entitled "*Safeguarding Children Involved in Prostitution*". The guidance required services to

> "*treat such children as children in need, who may be suffering, or may be likely to suffer, significant harm*".

However, the guidance also explicitly rejected arguments to decriminalise '*child prostitution*' stating that:

> "*The Government recognises there may be occasions, after all attempts at diversion out of prostitution have failed, when it may be appropriate for those who voluntarily continue in prostitution to enter the criminal justice system in the way that other young offenders do"* .

[12] Laming (2009:14)

[13] Working together to safeguard children: statutory guidance regarding inter-agency working to safeguard and promote the welfare of children

New Guidance was produced in 2009, with a shift in terminology, now being entitled "*Safeguarding Children and Young People from Sexual Exploitation*" and with a less ambiguous approach to the safeguarding requirements.

4.2.3. Nevertheless, there was also a growing body of knowledge about the sexual exploitation of children by groups of adults, for example in children's homes, but also as a result of a small number of high profile cases in towns and cities in the region. In 1999 5 men were charged, and 2 convicted at Leeds Crown Court following the sexual exploitation of 20 girls in a room above a taxi office. In Blackpool in 2003 following the disappearance of 14 year old Charlene Downes the police investigation identified widespread sexual exploitation in the town and Project Awaken, a specialist multi-agency team was set up in response and further convictions followed. In Keighley, West Yorkshire 2 men were convicted in 2005 following a major police investigation of up to 50 men believed to be involved in sexual exploitation. In 2007 major police investigations in Oldham, Blackburn and Sheffield all resulted in convictions of men involved in similar patterns of exploitation. This therefore was not a new or unknown phenomenon and it would be reasonable to expect that it would feature in Board discussions.

4.2.4. It has already been publicly acknowledged that although during these years there was developing national and regional evidence of patterns of Child Sexual Exploitation, professionals in Rochdale were generally not skilled at recognising or responding to CSE.[14] There were relevant local multi-agency policies available, for example in relation to sexual abuse or sexually active under 18 year olds which would have provided help and direction. However, in common with the picture nationally,[15] there were no policies specific to Child Sexual Exploitation or prioritisation of this issue from a strategic perspective effectively creating a vacuum in relation to local direction and offering some insight into why operationally practice in relation to CSE was often so weak.

4.2.5. In 2009 in response to the new Working Together Supplementary Guidance, the Safeguarding Board developed its own CSE multi-agency protocols in relation to Child Sexual Exploitation, but the absence of any arrangements to monitor the use of these protocols meant that the Board and its constituent agencies had no knowledge of their impact. It was not until 2012 that the Safeguarding Board produced its first Child Sexual Exploitation Policy and Procedure and a Performance Framework was put in place.

[14] RBSCB CSE Themed Review Sept 2011
[15] Barnardo's (2011:2)

4.2.6. In effect, prior to 2007 there was no evidence of any leadership role taken by the Board with regard to CSE and no local guidance regarding either good practice or procedures was made available for staff. None of the agencies had CSE policies or procedures. In 2007 a CSE protocol was produced by the Board largely reflecting current government policy; providing information regarding warning signs and requiring practitioners to use the current Child Protection procedures should they have a concern. Also in 2007 the Safeguarding Board set up a Sexual Exploitation Working Group (SWEG) led by the Head of Service for Children's Social Care. The Group's remit included gathering and analysing information about the incidence of the sexual exploitation of children in the Borough and in 2008 a Sexual Exploitation Steering Group (SESG) was set up to:

- provide guidance and direction to the SEWG;
- report the findings of the survey to the Board;
- make recommendations for improvements.

This effectively marked the starting point at which CSE was identified as a developmental task for the Board, however there is little evidence that this was led from the top or prioritised at a senior strategic level.

4.2.7. In June 2008 a report was provided to the Safeguarding Board which identified that 50 children were believed to be affected by, or at risk of, sexual exploitation in the Borough. This was noted to be a similar number to neighbouring authorities. The report further stated that the current level of intervention did not appear to be protecting the children and that there was a lack of a co-ordinated multi-agency approach. The conclusion of the report was that a multi-agency team (which eventually became the Sunrise team) should be established to respond to CSE in the Borough.

4.2.8. Progress in setting up the Sunrise Team was very slow from the outset with several months' gap before the next planning meeting took place. The team did not ultimately become operational until January 2010. There had been significant problems reaching agreement between the agencies over the funding arrangements and then problems recruiting a Social Worker to the team. Having been recruited the Social Worker left after approximately 6 months in post, reportedly unhappy that the time intended for his specialist role was eroded by his being overloaded with other work. No information has been provided that would dispute this analysis, and this therefore provides further evidence that at this time there remained an inability to prioritise CSE at a senior managerial level.

4.2.9. A number of agencies and contributors, including the Designated Nurse, DesNCP and the named nurse, NNCP, both now retired, have described a lack of priority given to the issue of CSE at the Board. During 2009 following the agreement to set up the Sunrise team, three Board Meetings took place, but at none of them was CSE

minuted as having been discussed. Concerns were also expressed to this Review by DesNCP that the amount of time spent at the Board and amongst agencies on the funding arrangements distracted the focus from the needs of the young people.

4.2.10. The Sunrise team consisted of a Detective Constable from Greater Manchester Police, a Social Worker (Senior Practitioner), a Crisis Intervention Team Worker and a Drugs and Alcohol worker from Early Break. The team was located in the Police Public Protection Investigation Unit, but the workers remained the responsibility of their own agencies. A significant number of agencies and individuals have expressed concern about the slow development of the Sunrise Team even when it was established, including its lack of managerial oversight. Early Break was one of the agencies which described considerable frustration about cancelled meetings, lack of leadership and a failure to include their service in work undertaken to develop protocols for the team, to which they had committed a worker.

4.2.11. A report on the Sunrise team's progress was undertaken for the Board in May 2010 and it was immediately apparent that the creation of a dedicated team had already led to the identification of a number of children at risk and referral of a '*significantly increased number*' into statutory agencies. However, the report also identified significant vulnerabilities in relation to the work including lack of a clear management structure, operational guidance or supervision of staff as well as insecure funding. Of note was that members of the team were still working as individuals, in part because issues of confidentiality had not been resolved and there was a lack of co-ordination and problems with adherence to Safeguarding Board policies.

4.2.12. The first Independent Chair of the Board, described a continuing absence of any responsibility being taken for oversight of the team by the key agencies. A new manager was appointed to the Sunrise Team and although supervision was to be provided by CSC, this did not appear to lead to improvements, particularly in regard to the development of policies, procedures and establishing the remit of the team. The Chair reminded the senior strategic managers in CSC of the new manager's need for support, but without success. Eventually the Chair met with the newly appointed manager herself on three occasions to support her in the task. The Chair was acutely aware that this was outwith her role, but nevertheless felt that given the inexperience of the manager who had been appointed and the absence of any progress in resolving the operational issues for the team, the risks of not doing so were greater.

4.2.13. Whilst the creation of a specialist team is generally viewed as best practice given the complex nature of Child Sexual Exploitation, it is crucial that it is part of an overarching strategy including clear guidance regarding the roles and responsibilities of other agencies and practitioners. It is not evident that there was any underpinning

strategy within which Sunrise played its part. Rather it appears that the development of Sunrise was developed before there were any strategic agreements as to how the team would fit into the broader picture of multi-agency working. This included weaknesses across the wider remit of the Local Authority, for example in relation to linking work within the wider community or disruption activities with the licensing authorities. [16] The lack of such a strategy can only be seen as a significant failing in the collective leadership, leadership which should have been provided by the core statutory agencies. This lack of leadership had significant consequences for the quality of operational delivery and provides some explanation as to why practice in relation to CSE failed to improve and was so poorly co-ordinated until comparatively recently.

4.2.14. A repeating concern that has been raised within this Review has related to the ability of the Board to meet its statutory functions, ie: co-ordinating multi-agency work and ensuring its effectiveness.[17] An understanding of the history and functioning of the Board is helpful in providing context to the difficulties it continued to experience in progressing the work of the agencies. From 2004 Boards were permitted, but not required to appoint Independent Chairs, an approach which has subsequently been recognised as creating a weakness in ensuring accountability and establishing strong partnership working. The Board had not had an Independent Chair, prior to August 2010. It had, since its inception, been chaired by either the Director or Assistant Director of Children's Services.

4.2.15. A number of agencies and contributors have commented on the central role held by Children's Services in decision making on the Board during this time to the unhealthy exclusion of other partners. The practice of appointing Chairs exclusively from Children's Social Care is likely to have been a contributory factor to the poor functioning of the Board, particularly with regard to a culture of shared responsibility.

4.2.16. The first Independent Chair of the Safeguarding Board was appointed in August 2010. She was informed that the Board had not evolved adequately from when it was an ACPC (Area Child Protection Committee) and was asked to review the Board structure and function. In consultation with the then Executive she established a new 2 tier structure alongside and a new multi-agency quality assurance framework. A survey of staff across agencies which was undertaken later that year by the Board confirmed this perspective that staff viewed Children's Services, as in effect the Board. The Independent Chair described what she believed were long established cultural and practical problems in partnership working at a senior level

[16] see RBSCB (2012) and Klonowski (2013)
[17] Sections 14 & 14a Children Act 2004

combined with external political and economic pressures which provide some insights into why the Board was proving so ineffective. These perspectives were also reflected by a number of other contributors as well as some of the factual information provided. They include:

- Role and status of Children's Social Care on the Board.
- A lack of political interest in the activities of the Board and the significance of prioritising child protection and responding to sexual exploitation.
- Historic and continuing political instability, with frequently changing or hung leadership in the council.
- Major resource issues, with the Local Authority required to make spending reductions of £52 million for the 2011/12 financial year. This was as a result of the Comprehensive Spending Review, a freeze on Council Tax and increased demand for social care services.[18] The level of the funding cuts had come as a significant shock to the Authority.
- As a result of the spending review, major organisational change and loss of senior staff was being planned across the council.

4.2.17. Irrespective of the predominant role of Children's Social Care on the Board prior to 2010, there was representation from all the key partner agencies and as such it could have been expected that developments would be cascaded through from strategic to operational managers and to front line staff. What has been of particular concern however is the lack of evidence that there was a clear channel of communication from Board members to their agencies. As such there existed a disconnect between information being presented and discussed at the Board and actions taken at an operational level within the agencies. A further example of this is that despite the June 2008 report being received by the Board and identifying the need for a specialist team, there is no evidence that this knowledge at a strategic level impacted on the response of agencies to the crucial allegations made by [redacted] in August 2008

4.2.18. A crucial example of this disconnect was the lack of response by Rochdale's Senior Leadership Team (SLT) in 2010 to DI1's request for additional resources for the police investigation. The Police IMR analyses this episode in detail, from the production of a comprehensive report by DI1 to the failure of the SLT to refer the investigation upwards to the Force Task Co-Ordinating Group responsible for allocating Major Incident Teams in complex cases. The decision not to refer upwards by the SLT has been acknowledged by them as a mistake and clearly identified by the IMR as an error of judgement. The Police have separately provided information to this Review about organisational changes which mean that such a request

[18] Rochdale Borough Council Annual Report 2010/2011.

would be received directly by the Head of Serious Crime Division and the Head of the Public Protection Division for assessment. The effectiveness of this is illustrated in a number of significant Operations including investigations of child sexual exploitation, which have since been resourced centrally. Given these changes no further recommendations have been made in this Review.

4.2.19. Within individual agencies there are several examples of gaps, either in the knowledge of operational managers as to what was being considered at Board level, or the priority that they believed they should give it. For example the YOT deputy managers could not recall ever discussing the cases subject to this SCR during formal supervision sessions with the YOT Service Manager and there is no evidence that information about developments at the Board was cascaded down the management structure to practitioners. There has been considerable discussion as to where the responsibility for this lies not least in the Home Office Select Committee[19] and also in the Report commissioned by Rochdale Borough Council and published in May 2013[20]. Little that is helpful can be added to these discussions other than to reiterate that the disconnect referred to, with its consequent implications for YP1-6, is quite apparent in the information provided to this Review.

4.2.20. It is also apparent from the brief history provided that the Board, irrespective of the best intentions and hard work of some individuals within it, had struggled to achieve a meaningful role in providing leadership and accountability for the multi-agency partnership. The shift to appointing an Independent Chair appears to have marked the beginning of an important change. However, like any significant organisational change this was not easy to achieve. What has been informative in observing the process of the current review is that both within the IMRs and within the SCR panel itself there remains a significant cultural theme by which the Board is seen as external to its partnership members, raising questions about the degree to which there is a sense of collective ownership and responsibility.

4.2.21. What has also become very clear during the course of this Review is that it was not only in relation to Child Sexual Exploitation that there was an absence of leadership by strategic managers. In considering the service provided to these young people, there is a noticeable absence of any evidence that there was senior strategic management awareness of the quality of safeguarding practice or a proactive focus on supporting best practice at an operational level during the relevant timeframe. A quality assurance framework is understood to have been developed for CSC by the first Independent Chair prior to her appointment into that role. After her appointment a separate

[19] Parliament: Home Affairs Minutes of EvidenceHC68 20.11.2012
[20] Klonowski, 2013

performance framework was developed for the Board itself, there has been no evidence provided that these were implemented.

4.2.22. There has, during the last year, been a major shift in the policy and practice approach to Child Sexual Exploitation, marked by formal reports to the Board by both the Sunrise team and Children's Social Care in June 2013 and a formal launch of the policy and procedures in July 2013. The Sunrise team is now established with clear governance, including protocols and procedures and is managed by the GMP Divisional Commander. The team is now more clearly set within a strategic framework, with specific pathways for referral and allocation of individual young people to a qualified social worker within the team. A measure of its progress can be established by assessing it against the Barnardo's checklist :

- *Q: What system is in place to monitor the number of young people at risk of child sexual exploitation?*

  A: The RBSCB has a full developed CSE performance framework and CSE report card. The framework is reported to the Board quarterly and a risk register is in place.

- *Q: Does your LSCB have a strategy in place to tackle child sexual exploitation?*

  A: The RBSCB has a CSE strategy the implementation of which is overseen by the CSE Subgroup and reported to the Board every quarter. The strategy is informed by local learning, national drivers, research and good practice examples

- *Q: Is there a lead person with responsibility for coordinating multi-agency response?*

  A: The Sunrise team (multi-agency CSE team) has a service manager. The Strategic lead for CSE is the Divisional Chief Superintendent from GMP

- *Q: Are young people able to access specialist support for children at risk of child sexual exploitation?*

  A: The Sunrise team is able to respond on an individual needs basis to young people at risk of CSE. The team comprises SW's, health workers, Police officers, youth workers, and has input from YOT, EWS. The RBSCB has undertaken a CSE briefing programme (see table below)

- *Q: How are professionals in your area trained to spot the signs of child sexual exploitation?*

Workstream	**Numbers Trained**
RBSCB CSE Agency Awareness Raising activity for staff & volunteers	Face to face training = 5,609 Memo / online training = 16,757

RBSCB CSE Seminars	89
RBSCB Specialist 1 Day Training for Managers	42
Youth Service Parental awareness sessions	Parents / carers attended = 195 Young people attended = 31
RBSCB & Education PHSE Leads in schools	50
CSE In PHSE Sessions in schools	760
RBSCB & Youth Services Young People's awareness Raising activity in schools (NB completed April 2012)	Young people 9,019
TOTAL Numbers	**Professionals 22,547** **Young People 9,810** **Parents / Carers 192**

4.3 The operational response: recognition of child sexual exploitation and the warning signs

4.3.1. As has already been noted, general professional understanding and therefore recognition of CSE was at a comparatively early stage in 2007. Accessible mainstream research was limited and the terminology of '*child prostitution*' used in government guidance (and reflected in the RBSCB CSE protocol of 2007) was unhelpful by current standards although it was updated in 2009. However, the Supplementary Guidance to Working Together, which included information on identifying children '*involved in prostitution'*, had been available since 2000 and should have been a key reference document for agencies involved in safeguarding children.

4.3.2. The route to recognition of CSE was as a result of either direct allegations or by significant warning signs and indicators which could have triggered a hypothesis of CSE or some other form of significant abuse in the young people. What has become evident in relation to all these young people, is that despite considerable information being available to many of the agencies that they were extremely vulnerable and that there was evidence they were involved sexually with older men, the possibility that they were experiencing sexual exploitation was not recognised by the key statutory agencies until the middle of 2008. It is also the case that agencies also often failed to understand the degree to which the young people continued to be exploited even when child protection procedures had been initiated.

4.3.3. The practitioners first known to have 'named' what was happening were the sexual health workers within the Crisis Intervention Team (CIT), who stated explicitly that the young people were being exploited. This team had regular contact with young people specifically in relation to sexual activity and as such were perhaps in a position to see patterns of behaviour more clearly than some other agencies. In 2006 CIT contacted Children's Social Care twice stating their concerns that [redacted] was being sexually exploited. CSC concluded that no Strategy Meeting or assessment was necessary nor was any action required other than offering support.

4.3.4. The response by CSC to this and the level of understanding it revealed was wholly inadequate given the nature of CITC's referral which stated: "*I believe that* [redacted] *is being sexually exploited and manipulated by a number of adult men. I also believe much of* [redacted]*s sexual activity is non-consenting and done under duress and threats of violence. I also believe* [redacted] *is given substantial amounts of drugs and alcohol in order to further impair her judgement."* The reason that CSC noted for not taking further action was that there was inadequate evidence regarding sexual exploitation, but in the absence of a proper investigation it is difficult to see how this conclusion was reached. Given that the information being provided by CIT identified potential

criminal offences against children, it was incumbent on CSC to contact the police and initiate a S47 enquiry, instead of which it would appear that a decision was made solely by CSC. Given the very limited information available it is difficult to conclude why this specific judgement was reached. However, the contributory factors which are likely to have undermined good practice include: lack of knowledge base regarding CSE and the controlling nature of the men's relationship with the young people; lack of good supervision and support; lack of agency understanding of CSE.

4.3.5. The unclear way in which CIT at times shared concerns with other agencies is considered further in Section 4.5. On this occasion CIT recorded that this particular information had been shared with the PPIU although the exact nature of what was shared is unclear. Whether the police should have taken action on this particular occasion is therefore difficult to judge. Nevertheless there is evidence that CIT did share concerns with the police prior to 2007 but that this did not lead the police to consider criminal investigation. Other agencies also recorded their understanding that this lack of active response by the Police was because [redacted] was over 16 and therefore there was little action that could be taken. Exactly what had been said by the Police that led to this understanding is unknown, but what is clear is that the Police were struggling to recognise the nature of CSE or to know how to intervene effectively at this time.

4.3.6. Greater Manchester Police had access to information from as early as 2004 [redacted]. The police were frequently contacted by the family and the IMR notes that their mother's "*repeated and clearly expressed concern that her daughter was consorting with middle aged Asian males was regularly recorded but rarely caused anyone to examine or action these reports.*" The IMR suggests that the frequency of [redacted] being missing from home led to a sense of apathy amongst police officers and as a result there was no consideration of any further action as long as she or her siblings were "*alive and returned home*".

4.3.7. At this time no specific local procedures existed in relation to children missing from home and therefore there was, for example, no trigger point at which the Police would have been expected to refer a young person who was frequently missing to Children's Services. Given the passage of time it is difficult to reach any conclusion as to whether this gap has implications for current practice. The Police deal with very high numbers of missing people with approximately 12,000 children being reported missing per year across Greater Manchester[21]. However, GMP did have a dedicated Single Point of

[21] A standardised approach to dealing with missing and absent people of all ages across Greater ManchesterPart A:Children and Young People (2012)

Contact (SPOC) for Runaways and no information has been provided as to why consideration was not given to making a referral to Children's Social Care. In particular the SPOC, or the PPIU might have been able to recognise a concerning pattern of behaviour even though this evaded the attending police officers. Rochdale Safeguarding Board and Greater Manchester Police now work to the Greater Manchester policy regarding missing children[22] As a result, frequent episodes of running away from home is now recognised as a potential indicator of child sexual exploitation and with hindsight this episode typifies the warning signs which are now more widely understood than was the case at the time.

4.3.8. Two incidents involving [redacted] that took place prior to the timeline for this review are of particular concern and need further examination in relation not only to the response of the Police, but also of the CPS. These are of particular note given that the combined response of the Police and the CPS had a significant impact on the way in which events subsequently unfolded.

4.3.9. In September [redacted] family reported to the police that she had been raped. There was no evidence of any investigation of this allegation at the time and in the words of the Police IMR "*the fact that she was alive and had returned home appears to have been sufficient for police purposes to treat the incident as having been concluded".* An officer from PPIU who subsequently visited the family was also reassured by the sisters that they were just friendly with a group of 'Asian' males, which given the age difference and the concerns of their mother should have triggered a much more inquisitive mindset.

4.3.10. Less than a fortnight later the police were contacted by [redacted]'s mother reporting her as having been driven off by three adult males and found [redacted] in a distressed state above Rochdale. On this occasion there was a police investigation and a file of evidence was sent to the CPS, which decided not to authorise a charge. A significant factor in the decision making by the CPS was the perception of [redacted] credibility, [redacted]. The CPS advice was therefore based very considerably on consent by [redacted] although given that she had also been physically assaulted , sustaining injuries the issue of consent could not have been an issue in relation to this allegation. It was also the case that the issue of consent did not need to be a consideration given her that [redacted] 16.[23] The CPS IMR further notes that the CPS focus appeared to be in looking for failings in the prosecution case rather than considering the weaknesses in the case for the defence. It is indicative of the approach taken that in assessing the evidential

[22] as 27
[23] Sexual Offences Act 2003

criteria the lawyer noted: *"the aggrieved is a young lady who is known for going with men and in particular Asians in this type of situation."*

4.3.11. Although a Detective Chief Inspector from Rochdale did subsequently write in general terms to the CPS with concerns, no formal appeal was made by the Police against the CPS decision, as they were entitled to do. The failure by agencies to pursue their concerns with other agencies is a repeating theme of this Review. Since these events there has been significant recognition by the CPS of the failings in their decision making at the early stages of these young people's experience and the need for a shift in mindset, policy and procedures. New guidance[24] from the CPS emphasises the requirement for periodic proactive joint review of cases by police and CPS lawyers in cases of child sexual abuse. The CPS is also developing a new approach to enable victims to appeal against decisions in their cases.

4.3.12. Whilst this is likely to provide an important safeguard in future decision making, it is the view of the author that the significance of the lack of police challenge to the CPS, which has been acknowledged as a feature of this case, requires more than a reliance on CPS procedures and merits active consideration on the part of Greater Manchester Police. This episode combined with the frustrations regarding allocation of resources felt by two experienced Police Officers, one of whom DI1, was evidently particularly committed to pursuing the investigation of CSE, suggests that this is part of a wider difficulty in challenge within the Police. GMP has provided examples to the Review to evidence that it is making progress in creating a significant shift in culture to encourage greater challenge and where necessary escalation by officers. However this issue is a longstanding and complex challenge for the Police which like any organisational cultural change will require persistence and objective review in the long term. A specific recommendation is therefore included in this report at Section 6.11 to establish a system which will monitor and review the use of escalation with regard to safeguarding cases both internally and to the CPS. This can then be linked to the escalation policy of the RBSCB. Such a recommendation is clearly not intended as a 'quick fix', but as a supporting contribution to a wider approach to organisational change given the experience of these young people.

4.3.13. A further defining incident also took place in August 2008 [redacted] were found at a takeaway and specific allegations of sexual abuse were then made to the police by [redacted] and other young people. This resulted in the first explicit police and multi-agency recognition that child sexual exploitation had taken place. From this point on police investigators appear to have understood that they were dealing with Child Sexual Exploitation. It should also have led, and as we now know, could have successfully led to criminal

[24] CPS: Guidelines on Prosecuting Cases of Child Sexual Abuse Oct 2013

convictions. A police investigation took place although it was nearly 12 months before a file of evidence was sent to the CPS for a decision regarding charging. That the investigation took this length of time is of concern and has been considered in the police IMR which concludes that it was in significant part due to a lack of resources being provided for this investigation.

4.3.14. The investigation was taken over by a Detective Sergeant from CID in the autumn of 2008. This officer unlike his predecessor had no specialist child protection expertise and it is likely that this impacted on the progression of the investigation. The officer had initially believed he would be able to manage the investigation alongside other work, but by January 2009 had recognised that it was too complex for him to work on alone and wrote to the Detective Inspector seeking additional resources. In his e-mail he described this as *"a lengthy enquiry with numerous people to arrest. It will have a high profile within Social Services with many multi-agency meetings.*" One multi-agency meeting did take place as a result, but the investigating officer never received a response from the Detective Inspector regarding the issue of resources and so he carried on the investigation without the benefit of further resources.

4.3.15. The investigating officer with hindsight regrets that he did not pursue the matter further, again illustrating a lack of a culture of internal challenge within the police. What it further illustrates is that at middle management level in the Rochdale Division there was a failure either to recognise or to prioritise child sexual exploitation at this time. As has been noted previously, it further illustrates the gap between what was taking place at Board level and the way in which operational decisions were impacting directly not only on this investigation but the also on Police capacity to engage some of the young people in their investigations subsequently.

4.3.16. The file of evidence having been submitted to the police in August 2009, a decision was again made by the CPS not to charge the two alleged offenders. The CPS IMR analyses this decision in detail and identifies some key errors in the way the judgement was reached. These included a mistaken view that DNA evidence could have been effected by cross contamination and a focus again on the credibility of [redacted] as a witness. The IMR points out that the DNA evidence would in any event clearly have proved that an offence of Sexual Activity with a Child under 16[25] had taken place. But also considers that had further information been sought about the pattern of abuse against the young people "*the broader picture of child sexual exploitation would have emerged*".

4.3.17. It is apparent that the CPS analysis of the evidence was significantly influenced by perceptions regarding [redacted]'s credibility and a lack of understanding of sexual exploitation. The CPS lawyer, as was

[25] Section 9 of the Sexual Offences Act 2003.

required, sought a second opinion, however as this opinion did not review any of the evidence, it was in the words of the IMR author "*'devoid of value*". Given that the first lawyer was comparatively inexperienced the lack of any meaningful oversight of his decision making was particularly significant. It is notable that the lawyer providing the second opinion stated *"It is a tragic case that one so young has fallen into this lifestyle and has been taken advantage of in this way*." This again demonstrated a failure either to recognise or to understand the nature of sexual exploitation and an assumption that [redacted] was making a choice, despite the fact that she had made a specific allegation of rape. The concept of being '*taken advantage of*' should have been understood in that context. The failure to progress to criminal charges left the young people distrustful of the Police and more vulnerable to being exploited.

4.3.18. In contrast there was a totally different response by the CPS when contacted by Operation Span officers in December 2010. CPS lawyers on this occasion immediately gave the case a high priority and started from the viewpoint that 2009 decision should be overturned and the two men prosecuted. The lawyer allocated, CPS2, provided what is described as an excellent analysis of the evidence which in turn meant it was decided by the Chief Crown Prosecutor for the North West to overturn the original decision. [redacted] Father told the Review that this decision was a direct result of pressure on the Chief Crown Prosecutor by CIT, but no other evidence has been provided to corroborate this view. A separate decision was also taken, despite some difficulties with the evidence, to charge AdultD.

4.3.19. Although it would be speculating to suggest a specific reason for the change in response at this point by the CPS, it is probable that a number of factors came together including:

- Quality of the police investigation and evidence provided.
- Growing understanding of the phenomenon of child sexual exploitation in the intervening period.
- Knowledge base, attitudes and skills of individuals within the CPS.

4.3.20. The response of Children's Social Care to the young people in the early years repeatedly showed a lack of understanding of CSE both at the point of initial assessment and also in relation to repeat exploitation. The predominant response by staff in CSC was not to identify that the young people required safeguarding, but rather to focus on the problematic behaviour of the young people with limited evidence that practitioners analysed what was underneath the behaviour. This response did not represent an individual failure by individual practitioners but a pattern across a number of workers over time, unchallenged by their managers, suggesting that the problem was an organisational one. Examples include:

- July 2004: 15 year old [redacted] accommodated overnight after being taken into police protection. [redacted] spoke of wishing she was dead

and there was information that she was frequently in cars with adult males.

- 2007: information provided by CIT that [redacted], who was 15 years old, was 16 weeks pregnant, suffering from a sexually transmitted infection and had an older sister who had reportedly been sexually exploited
- 2009: Initial assessment of [redacted] concludes she is no longer at risk of sexual exploitation as her parents were protective and she had some support from agencies

4.3.21. The CSC IMR identifies a number of explanations as to why CSE was not recognised. Conversations with three social workers who were part of the duty and assessment team at the time suggested that the following factors influenced the practice:

- high workloads and difficult work environment
- lack of challenge by managers in relation to assessments
- focus on younger children in the wake of the death of Baby Peter
- lack of staff training on CSE
- a view that extra familial sexual abuse was primarily the role of the police.

These explanations are certainly likely to have been part of the underlying context, although given the passage of time and the degree to which memories will have been influenced by the professional and public focus on these events, the degree played by hindsight in some of these reflections is difficult to assess. The high workloads in the duty and assessment team were specifically confirmed in the OFSTED inspection in 2009 and this led to a decision by the authority to increase staffing numbers. Other factors that impacted negatively on front line practice included:

- the lack of any assessment tool which would have helped to identify that aspects of behaviour were symptomatic of child sexual abuse
- Absence of child focused supervision by front line managers

However relevant these explanations, they still fail to fully illuminate why child protection professionals faced with young people displaying a wide range of worrying warning signs, did not recognise that they might be experiencing significant harm. There has been considerable comment on the concept that Social Workers and others simply assumed that the young people were making a 'lifestyle choice' and this will be considered further in Section 4.4.

4.3.22. Whilst CIT, the Police, the CPS and Children's Social Care were presented with direct allegations of exploitation many of the other agencies were aware of a range of information and warning signs which should have triggered greater concern and reflection as to what was happening in these young people's lives, irrespective of whether

the concept of CSE was familiar at that time. Whilst there is now much greater professional awareness of the sort of indicators to look for[26] many of the behaviours and indicators were visible to the different agencies. The Rochdale Borough Safeguarding Children Board, Multi Agency Protocol on Child Sexual Exploitation, 2007 included a section on Recognition which listed indicators including:

- physical symptoms eg sexually transmitted infections or bruising suggestive of either physical or sexual assault
- reports from reliable sources suggesting the likelihood of involvement in prostitution
- repeatedly consorting with adults outside the usual range of social contacts
- repeatedly consorting with children known to be involved in prostitution
- persistent absconding or late return
- a history of sexual abuse or poor self-image.

Had practitioners referred to these Board procedures many of those agencies individually would have identified several of these indicators as being visible in the young people. Whether staff were familiar with this protocol is unclear but it has been suggested that it was not widely known or used. There is also no evidence that this information was either known or used by front line managers.

4.3.23. The Education Welfare Service for example has specifically noted that there was no process for the recognition and recording of Child Sexual Exploitation within supervision meetings at this time. This was despite the involvement of two senior managers from that agency on the Safeguarding Children Board during this period, which could have been expected to raise awareness of CSE. However, it is also the case that the focus for most Education Welfare supervision was largely on dealing with 'next steps' in difficult cases. The service has reported limited capacity given rising caseloads to consider any wider welfare issues or to look more broadly at the effectiveness of strategies in working with young people. As such the absence in any capacity to reflect on CSE in supervision was part of a wider problem for the service which has led to a Recommendation by that agency.

4.3.24. This further reinforces what has already been identified regarding the gaps in effective communication at a strategic level and the lack of a policy focus on CSE at this time. This will inevitably have been one of the reasons why the level of recognition was so limited. The absence of any system for audit regarding implementation or compliance meant that agencies themselves would not have been able to explain whether their staff were aware of the existence of the policy and if not, why staff were failing to make use of this tool.

[26] reference Barnardos etc here

4.3.25. Significant information was available within the School setting and in relation to Education Welfare regarding concerns [redacted] from at least 2004. These were predominantly concerns about behaviour and absence from school, but also related to explicit racist attitudes and aggression towards 'Asian' pupils and that the girls were sexually active at a very young age. Several senior school staff did identify these as safeguarding concerns, even though they often did not fully recognise that Child Sexual Exploitation was taking place. Referrals and specific concerns about neglect were raised with Children's Social Care but generally failed to lead to an effective response. The reasons for this will be considered further in section 4.5.

4.3.26. All of the young people had a high level of contact with a range of health provision and there was evidence of general recognition that the young people were vulnerable and had particular needs. However, this was not in the early stages, other than by CIT, translated into a recognition of CSE.

4.3.27. All the young people attended A&E on a number of occasions. in particular had periods of very frequent attendance often late at night, yet there is very little evidence that the underlying reasons for this was questioned by staff or by her GP who was routinely informed of the attendances. The recent "*Shine a light*" report[27], a survey of Health Professionals prepared on behalf of the National Working Group commented that lack of recognition of CSE was felt to be a common problem nationally rather than something unique to a particular group of staff:

> *"One Named Nurse for a Hospital Trust felt that A&E is the riskiest place in the hospital but there was a lack of awareness around CSE in that department. An experienced A&E Charge Nurse had said "when it comes to sexual exploitation, we do not know what we are doing". A&E staff feel that they are just too busy to look fully into cases and "opportunities are missed when teenagers want to talk."*

4.3.28. A very significant indicator of sexual exploitation is early sexual activity, symptoms of sexually transmitted diseases and pregnancies at a young age. These were frequent features of the young people's contact with health services, but nevertheless did not trigger consideration of Child Sexual Exploitation.

4.3.29. Two of the young people [redacted] accessed termination of pregnancy services at quite a young age and these occasions both created opportunities for those working in health to consider what was happening to them and what their wider needs were, but there is little evidence that this was the case. [redacted] who was then 14 years old, asked the School Health Practitioner for a pregnancy test which proved positive and was then referred to CIT. [redacted] told CIT that she

[27] Shine a Light NWG 2013

had had sex two weeks previously with a 21 year old man, that she had not seen him since and that she did not want her mother to know. The option of termination was discussed with her, but there is no evidence that the fact that this 14 year old girl had had sex with a man considerably older than her was pursued any further. It is of further note that three days later CIT recorded that a Strategy Meeting about sexual exploitation had taken place at which [redacted]sister, [redacted] was discussed but no apparent connection was made with the circumstances of [redacted] pregnancy and there is no evidence that this information was shared at the meeting.

4.3.30. [redacted] subsequently attended at the hospital for a termination. It is of concern that the focus appears to have been purely on the clinical need. There is no evidence that consideration was given to safeguarding concerns despite [redacted]s age, the stated age of the father and her known home circumstances. Neither was evident curiosity aroused by the fact that she attended with a man identified as her uncle (father's stepbrother.) This man's name was not recorded, but it was stated "*is supporting her but is known to the Child and Family Team".* This is unfortunately ambiguous as it is not clear if it intends to convey positive or negative knowledge. The fact that [redacted] also had a sexually transmitted infection should also have triggered professional curiosity and concern as to whether this was in fact her first sexual encounter.

4.3.31. [redacted] was assessed during Court Proceedings [redacted] as having a moderate learning disability, although there is no information that this was recorded in any previous health records. Nevertheless that several health professionals were unable to identify that [redacted] might be a young person with additional needs is of concern. It is also of interest that [redacted]s notes include the following comment: *"looks mature for her age"*. The notes provide no explanation as to why this was relevant to the clinical decision, or whether in fact a judgement had been made linking [redacted]'s sexual and emotional maturity with her outward appearance.

4.3.32. In February 2009 the 13 year old [redacted] also sought a termination. At the initial appointment with her GP it was noted that she did not appear to understand the implication of her pregnancy and both the GP and the practice nurse referred to her baby like behaviour. The Practice nurse also questioned her competence to make the decision. [redacted] told the GP that the father was "*an older Asian male*".

4.3.33. [redacted] subsequently attended the Pennine Acute Hospital Trust for a termination accompanied by her mother. [redacted] was described as appearing to be finding the process very difficult and was aggressive. As a result an assessment was arranged a few days later with an adolescent psychiatrist who concluded that [redacted] did have capacity to consent to the termination. In any event [redacted]'s mother also countersigned the required consent form. It was following this that the Police requested, and received from PAHT, the foetal material

resulting from the termination as potential evidence in relation to Operation Span.

4.3.34. [redacted]'s GP had contacted the allocated social worker as [redacted] was subject to a Child Protection Plan, but there is no evidence in the IMR as to whether this was known to the hospital medical staff, or that hospital staff contacted Children's Social Care or considered the implications. As with [redacted] the phrase *"looks mature for her age"* is included in the notes, with no explanation of its relevance. Given [redacted]'s age, her evident vulnerability, her additional needs and the description of the father, good practice would have been to make further enquiries or refer to Children's Social Care for a fuller assessment.

4.3.35. The Panel, and the Independent Author, considered that there was inadequate information regarding these events within the IMRs. As a result Pennine Acute, Pennine Care and Greater Manchester Police were all given the opportunity to provide further information and additional information was submitted by each of the agencies by the Panel members for each agency.

4.3.36. Pennine Care provided further information about the assessment undertaken by ConsPsych1, which had not been included in the IMR. The information is detailed and specific including reference [redacted]'s views and evidence that ConsPsych1 sought reassurance that she had support. However, what has been acknowledged is that although the psychiatrist did consider [redacted]'s wider welfare and recorded that others were involved, there is no evidence that ConsPsych1 adopted a pro-active role by contacting Children's Social Care or the Police herself and sharing her knowledge and any concerns directly. In reviewing this episode, Pennine Trust has acknowledged that their Consent to Examination and Treatment Policy makes no reference to Safeguarding and that this is a weakness which is now being reviewed.

4.3.37. Greater Manchester Police have acknowledged that whilst their request to the hospital for the foetal material was lawful, and that they believe that the officer was acting in good faith, with hindsight this had not been handled in the most sensitive way and there was a lack of focus on the ethical issues. The Police Officer was concerned to find evidence as part of a serious criminal investigation. However, [redacted] should have been informed. In any event the DNA testing was not able to identify a specific 'offender' at that time. However the sample was retained and in the Operation Span investigation it was confirmed that it linked to a man who was subsequently convicted of offences against [redacted] Whilst GMP describe information being given to [redacted] and her mother [redacted] obtaining express permission to resubmit the retained material for further testing obtained from [redacted], along with a DNA sample from [redacted] herself, her comments after the trial suggest that this remained an issue of concern for her.

4.3.38. GMP have informed the Review that in 2009 there was little guidance as to how to deal with such a sensitive subject, but this has since

been recognised as a weakness and in 2010 GMP produced a Human Tissue Act Policy which is itself currently under further review.

4.3.39. The Pennine Acute Trust IMR identified within its IMR a clear underlying theme of "*poor recognition and practice regarding social issues and lack of recognition regarding child protection issues in young people particularly within the acute Accident and Emergency setting.*" However the lack of any analysis by the IMR of the safeguarding practice within the setting of gynaecological or genito-urinary medicine represents a significant gap in the Trust's learning. The reasons why there was no evident focus on the young people's welfare concerns, not simply on the clinical or legal issues, within these departments, with their very different roles, procedures, focus and pressures from the A&E department therefore remains unknown.

4.3.40. The Pennine Acute Trust has stated that it was satisfied that it met all its required standards in relation to [redacted]s competence to consent to treatment. However this does not adequately answer the questions about whether health professionals concerned at this key point in [redacted]s story took a proactive approach towards her safeguarding, whether they knew or considered the implications of 111 being subject to a Child Protection Plan. The Health Overview has, as a result of this further information provided a Recommendation to health commissioners to review health services which provide sexual health services to young people and consider the extent to which safeguarding and child protection are considered as part of sexual health assessments.

4.3.41. The Pennine Acute Trust also provided additional information to this Review about the way in which the issue of [redacted] termination and the subsequent request by the police was managed. The Trust has identified that ConsGyn1 '*liaised*' with CIT, the GP, CSC and the Police. No further information of note has been provided, for example: the nature of any communication; who was spoken to and at what point; what was the purpose or outcome of liaison. Neither is there any corresponding information from any of the agencies concerned which might provide that information. What is therefore still missing is any evidence as to what impact this activity had on PAHT's professional contribution to safeguarding, or whether the liaison was in fact purely related to the clinical role and the legal issues raised by the Police. The lack of any detailed information regarding what issues were taken into account in responding to the Police's request, and also what focus there was on the safeguarding and ethical concerns for [redacted] means that the quality of PAHT's safeguarding practice in this setting remains unclear and an opportunity for wider learning has been lost.

4.3.42. This Review therefore recommends to Pennine Acute Health Trust that it gives further consideration to the implications of these episodes [redacted]

4.3.43. The issue of the terminations has been considered in detail as they are particularly powerful examples of a gap between the response to

clinical need and the ability to recognise CSE and take a proactive role in safeguarding. They are not however the only examples which might have led to a consideration of some form of abuse or exploitation and led to action such as a referral to Children's Social Care or consideration of a CAF including attendances for:

- repeated requests to the GP by [redacted] for emergency contraception
- episodes of self harm
- overdoses
- depression
- poor self care

4.3.44. Nevertheless there was also a not insignificant number of occasions when both health staff and others identified significant concerns about the young people, even though they may not have linked these to CSE. These included:

- [redacted] a Midwife identified a range of concerns regarding [redacted] social history, including: father's drug abuse; father of baby unaware of pregnancy; incidents of domestic violence within the family.
- Identification by [redacted] school [redacted] that outside of school she was "exposed to risks beyond her capabilities"
- Police and CPN raising concerns in [redacted] regarding home conditions [redacted] including Domestic abuse and drug and alcohol use.

4.3.45. The failure to connect these events in the young people's lives with the possibility of sexual exploitation is likely to have been influenced by a number of factors. One recurring feature is the limited expectations of these young people evidenced by a range of professionals, which will be discussed in more detail subsequently. Another is the lack of CSE specific knowledge. What has also been identified is a particular impact within Rochdale as a result of national health policies on local priorities and culture.

4.3.46. Commissioners of sexual health services are required to ensure that health practitioners pay due regard to reduction of teenage pregnancy and sexually transmitted infection rates. Between 2000 and 2010 the UK had the highest rates of teenage pregnancy in Western Europe. Rochdale Borough in turn was identified as having one of the highest rates of teenage pregnancy nationally. There was also a greater than average incidence of sexually transmitted infection in young people below the age of 18 years locally. The drive to reduce teenage pregnancy, whilst commendable in itself is believed to have contributed to a culture whereby professionals may have become inured to early sexual activity in young teenagers . The culture from the top of organisations concerned with teenage pregnancy focused on meeting targets for the reduction of teenage conception and

sexually transmitted diseases sometimes to the detriment of an alternative focus - the possibility that a young person has been or is at risk of harm and action other than clinical responses are required

4.3.47. Irrespective of whether individual agencies or practitioners consciously identified that the young people were at risk of or experiencing CSE, what should have been clearly evident was that all the young people were extremely vulnerable. Whether or not it the label of CSE was in common use, there were significant indicators that the young people might be experiencing sexual abuse as well as at times, direct evidence of abuse. In particular the two sibling group [redacted] lived within families where there were longstanding problems including domestic violence, indicators of neglect, and in the case of [redacted] the children had been subject to Child Protection Plans due to previous allegations of sexual abuse and neglect. All 6 young people evidenced challenging and worrying behaviour including being missing from home and very early sexual behaviour.

4.3.48. What should have been recognised, irrespective of the degree of understanding of CSE was that these were vulnerable young people, experiencing neglect and lack of parental care at a level which should have triggered safeguarding proceedings. Where this was recognised it failed to lead to effective intervention the reasons for which are explored further in the following sections.

4.4 The operational response: Understanding and engaging with the young people

4.4.1. Closely linked to the initial capacity to recognise CSE as a risk to the young people, was the degree to which the agencies showed an understanding of the young people's lives and were able to build relationships with them. Whilst with hindsight we can readily recognise the indicators of what was happening, it would not always have been easy to reach a conclusion at the time that the young people were being sexually exploited. There was however enough shared knowledge over several years to identify that these were young people with longstanding problems and needs.

4.4.2. What was needed was a determination to understand those problems, including seeking to understand why the young women appeared to be living so much outside the home and what was the relationship between their family experiences and their "*challenging behaviour*" outside of the family. Professionals needed to adopt a determined and persistent approach in order to understand the young people and to engage their trust and involvement. Again the picture is mixed both between agencies and within agencies. There are however some common themes which are repeated throughout the 5 year period and with each of the 6 Young People, suggesting that where there were problems these were not simply a result of individual shortfalls in

practice, but part of a wider collective inability to understand and engage with the young people.

Assessment: "*Children in families without detailed assessment are four times more likely to suffer repeat abuse"*[28]

4.4.3. The most critical weaknesses lay in the quality and timeliness of statutory assessments undertaken by Children's Social Care. There were too many occasions when despite significant information having been provided by the young people or by others, Children's Social Care failed to meet basic standards of practice in assessment and as a result were unable to understand their experience or establish trust and confidence in the young people.

4.4.4. Two Initial Assessments took place in quick succession in relation to [redacted] following the initiation of the police investigation focussed around the takeaway in [redacted]. The first Initial Assessment undertaken in [redacted] concluded that a Strategy Meeting was required, although the assessment itself is described by the IMR author as "*minimal in content with no evidence of having used the assessment of needs triangle framework or having seen* [redacted] An Initial Assessment is by its nature a first brief assessment and there may have been difficulties meeting with [redacted] in the timescale required. However, there is nothing to suggest that attempts to meet her were actually made or that there was any acknowledgement that this was a significant gap in the Assessment that would need to be met before further decisions were taken.

4.4.5. What is inexplicable however is that the subsequent S47 Core Assessment, which took a further two months, was also completed without any contact with [redacted] and that both assessments were countersigned by the Social Worker's manager. There is a fundamental expectation that children, including babies and very small children will be seen by the assessing Social Worker. Ascertaining a child's wishes and feelings is a requirement of the Children Act 1989 and there is statutory guidance regarding the assessment process which constitutes an absolutely basic tool of social care assessments.[29] For a Social Worker not to speak to a young person directly about experiences of which only she had full knowledge, is very hard to understand and appears to have set the tone for future engagement with her.

4.4.6. The assessment concluded that although the concerns that [redacted] had been sexually abused were substantiated she was not considered to be at continuing risk of harm. Such a conclusion, shows the serious shortfall in understanding of Child Sexual Exploitation and given the lack of involvement of [redacted] in the assessment, represents a disregard for her ability to contribute to the process and a failure to recognise

[28] ***C4E0 knowledge Review 2010***
[29] Dept of Health 2000 & Working Together (2000 & 2010)

that she was likely to be the most important source of information. The assumption, frequently repeated in other assessments, was that [redacted]'s parents could protect her, whereas even the limited information about the family history that was available might have suggested otherwise. There is also no reference to Social Work involvement in an Achieving Best Evidence[30] interview which should have taken place.

4.4.7. The second Initial Assessment that took place in relation to [redacted] was in [redacted] following a referral from the school after [redacted] had disclosed that she had had sex with [redacted] "*well known family*". [redacted] was 15 years old. Again, the Social Worker did not meet [redacted] only with her parents. Her parents suggested that [redacted] had '*fabricated*' the disclosure. There is no evidence that the Social Worker explored with the parents why they would think their daughter would invent these allegations, or why they did not appear to be more concerned about her being at risk. [redacted]'s parents also reassured the Social Worker that they "*took on board the seriousness of the allegations*". These two statements would appear to be quite contradictory and the Social Worker should have made efforts to speak to [redacted] by herself and reflected on the fact that this was a second allegation of possible sexual exploitation, this time involving different perpetrators, about whom there appeared to be some previous information. Again the assessment, which concluded with a recommendation for Intensive Family Support appeared to be focussed on [redacted] family, not on [redacted] and her needs. Again, the assessment was countersigned by the Social Worker's manager in effect endorsing the assessment as being of the required standard.

4.4.8. Subsequent assessments in relation to [redacted] were focussed on her child, with the view of the social worker recorded that the concerns about [redacted]'s contact with Adult D which led to the referral on this occasion did not warrant further investigation. Later in 2010 Action for Children raised concerns with CSC about [redacted] emotional well-being and use of alcohol and agreed after discussion with the duty Social Worker to undertake a CAF. Whether, given what was known about [redacted]s previous history it would have been more appropriate for CSC to undertake an Initial Assessment at that point is probably debateable. However, the outcome of the CAF was for a referral to Children's Social Care. An Initial Assessment was undertaken and concluded with a referral for family support. No information has been provided as to the content or quality of the assessment. It appears from the records that it was completed within one day and there is no information as to whether [redacted] was part of the assessment or what other information formed part of the assessment. It is noted however by the IMR author that the focus was on [redacted] son. Another Initial Assessment took place in [redacted], but again there is minimal information as to content or quality, although again the focus appears to have been on [redacted]

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4.4.9. As such there were 4 formal assessments undertaken in relation to [redacted] but very little evidence that any of these assessments were of a good quality or that [redacted] was properly engaged in the process.

4.4.10. Information regarding the assessment process for the other young people paints a very similar picture of limited historical context, no reference to chronologies, very little if any evidence of the wishes and feelings of the young people obtained and an over reliance on parental assurances. Historical information was known to Children's Social Care regarding the family of [redacted] yet there is minimal evidence that this contributed to various Initial and Core Assessments which were undertaken. Significant historical information seems not to have been collated or understood, for example in July 2004 [redacted] spoke of wishing she was dead which should have raised significant concerns, particularly given the specific reference to '*setting fire to herself*". Nevertheless the Initial Assessment focussed on how her mother managed this behaviour, and failed to grasp the level of risk and need that [redacted] was demonstrating.

4.4.11. [redacted] had been subject to Child Protection Plans when they moved from Area D to Rochdale and there was evidently quite a lot known about the family, including concerns about parenting and risks to the children. In [redacted] there was a referral from the school in relation to [redacted]. It was recorded that an Initial Assessment was initiated, but no evidence of it having been completed, although the outcome was a referral to CAMHS. There is no information in the records provided about what actions were taken in order to complete the assessment or whether [redacted] was seen.

4.4.12. Another Initial Assessment was undertaken in [redacted] on this occasion it would appear in relation to both [redacted]. The assessment noted ongoing concerns about the mother's chaotic lifestyle, poor home conditions, substance abuse and the children witnessing domestic violence. Again there is no information as to whether either of the young people was interviewed as part of the assessment.

4.4.13. What was notably lacking in these assessments was any sophisticated reflection about the young people's family dynamics and what this might reveal about their current behaviour and circumstances. There is no evidence that any tools were used to contribute to the assessment for example, self-assessment questionnaires, genograms or chronologies, which given the complex history of this family would have helped provide a more robust basis for assessment.

4.4.14. Social Work Practitioners were also provided with completely inadequate management support and oversight. No evidence has been provided of meaningful, challenging or reflective supervision in relation to assessments. Direct evidence shows us that assessments which fell significantly below minimum standards were nevertheless countersigned by managers, in effect confirming to practitioners that they were meeting the standards required of them. Where there is

information recorded about supervision it is largely functional, detailing new pieces of information or confirming that an assessment was due for completion. There is no evidence of any professional discussion, which given the nature of assessment teams with their high work throughput and the complexity of the work undertaken is of particular concern.

4.4.15. The absence of meaningful supervision has been noted in the IMR but is not subject to a recommendation. However the supplemental report submitted by CSC has explicitly recognised this as an area of learning which requires urgent action and this is therefore included as a recommendation within this report (See Section 6.6)

4.4.16. The absence of assessment of the young people's family dynamics led to a failure to understand their current problems in any context; a failure to recognise when their needs were not being met in the home including the existence of neglect; and also a failure to properly understand the families' ability or commitment to protecting their children outside the home.

4.4.17. This Review has exposed significant shortfalls in assessment practice, not only in relation to the specific issue of Child Sexual Exploitation but also in regard to deep rooted family problems and neglect. Individual social workers have a professional responsibility for the quality of their practice, and in this case failings in the professional standards of some Social Workers have resulted in formal action by the Local Authority, as well as referrals to their professional body. However, the scale of the failings must indicate fundamental organisational problems.

4.4.18. A key indicator as to why the quality of assessments was so poor has been identified in information provided by the previous Assistant Director of Children's Services. The Review was informed that the Borough had operated a policy for a number of years of investing in non-qualified social work staff. This policy was in the context of economic savings, but was also part of a wider decision in principle to move towards a more diversely qualified social care work force. It has been confirmed by staff working in the authority at the time that these staff were not simply providing different skills and experience, but required to take on aspects of the role that had previously been undertaken by Social Workers. This approach at times included, amongst other tasks, the completion of Initial Assessments. Parenting Assessments were also undertaken by non-social work qualified staff. It is likely that some of the staff undertaking Parenting Assessments had other relevant qualifications and may have been appropriately skilled and qualified, but this has not been evidenced.

4.4.19. The practice of delegating social work tasks to such staff was specifically criticised by OFSTED inspectors in 2009 and 2010. On at least two occasions non-social work qualified staff are known to have been required to undertake Initial Assessments (January 2007 para 3.2.3 and February 2010 para 3.4.46). Statutory guidance is explicit: "*The Initial Assessment should be led by a qualified social worker who*

is supervised by a highly experienced and qualified social work manager."[31]*.* This practice, which the Review has been informed was ended in 2010 by the Assistant Director at the time, was dangerous, compromised both the young people and the staff concerned and was outwith statutory requirements. That such an approach was seen as appropriate provides an insight into the degree of focus on the quality of assessments undertaken by Children's Social Care and the priority given to them by the organisation at this time.

4.4.20. This analysis has focussed on the quality of assessments provided by Children's Social Care's because of their pivotal role in the Child Protection process; however, problems with assessment were not unique to that agency. There were also significant problems in the quality of assessments undertaken by the YOT team, which given the social work component of this service is also of concern. The service uses nationally agreed tools for assessment, yet also acknowledges that assessments of vulnerability in particular were "*worryingly inconsistent*" with one practitioner rating [redacted] as 'high risk' and another as "not applicable".

4.4.21. The YOT IMR has identified that this was a result of two particular issues: a capability issue in relation to one non-social work qualified staff member and the use of separate information systems for staff working with non-statutory and statutory orders. It has also emerged; as a result of this Review that there was confusion about who was responsible for the supervision of PAYP workers employed by the Youth Service but seconded to the YOT team. YOT managers appeared to be unaware that case supervision for this group of staff was their responsibility according to the Service level agreement and it is worrying that this had not been identified previously. PAYP workers formal supervision was sporadic and for several months did not include any discussion of [redacted] Whilst the worker felt supported on an individual level by the YOT Deputy Manager, what was missing was in depth discussion of cases on a regular basis to allow the worker to reflect and to ensure proper managerial oversight.

4.4.22. Whilst it remains unclear as to why workers did not routinely communicate with each other or why, at an operational or strategic management level, these problems appear to have been either unrecognised or unresolved, the YOT IMR has identified that these issues have now been resolved. In the last 4 years the YOT has been subject to 3 full inspections. These have reported marked improvements in management oversight, assessments and interventions. and the performance of the YOT in safeguarding young people has been graded as 'Good' on the past two occasions. Given this, no further recommendation will be made within this Review.

[31] Working Together (2010; 147)

4.4.23. Whatever the actual quality of YOT practitioners' individual understanding of the young people was at the time, there is little in the information provided to this Review to evidence that their knowledge and assessments were of a high quality. For example [redacted] attended a school for children with emotional and behavioural difficulties and was identified as having Special Educational Needs, information which was known to the YOT workers. Yet at no point did the YOT assessment identify the possibility of Learning Disability or Difficulties. Equally there is no evidence of any significant reflection as to the root causes of [redacted] often quite disturbing behaviour, such as her repeated assaults on teaching staff and her racist comments. What is instead presented in the YOT IMR is a somewhat narrow focus on the defined 'offending behaviour' with little accompanying context or recognition that the organisation was working with children in need.

4.4.24. That there was such a narrow focus on offending behaviour needs to be understood in the context of the national policy imperatives with regard to youth offending. Reform of the Youth Justice system began in the late 1990s culminating in the Crime and Disorder Act 1998. This resulted in a fundamental change from a 'welfare' approach focussed on the needs of young people to one overriding objective: "*to prevent offending by children and young persons*"[32]. This shift in policy has created a significant tension in managing the national policy requirements regarding Youth Crime whilst also responding to the safeguarding needs of young people. It has been acknowledged by the Service Manager that like other authorities the YOT in Rochdale found this a difficult tension to manage. The impact of these at times contradictory requirements on YOT staff is believed to have contributed to the poorer standards of practice when judged from a safeguarding, rather than an offending perspective.

4.4.25. Across the services there was a range of information about the young people's families which should have led both to greater concern about the care they were receiving and to a more sophisticated and holistic understanding of their experience. What focus there was on family members was primarily in relation to the parents, particularly the mothers, and any immediately visible siblings. In common with what is known from many other Serious Case Reviews[33] men in the family are often in effect invisible as was the case for [redacted] with professional involvement focussed on the young people's mothers. There was however rich information regarding the wider family that either was not effectively shared or appears not to have been given any meaningful consideration. Examples of information that should have triggered further interest include:

- [redacted]'s brothers had been involved with the YOT team over a 5 year period, but there is no evidence of links having been

[32] Crime and Disorder Act, 1998 Section 37
[33] ref biennials

made with [redacted] experience or this knowledge about the family shared in child protection meetings.

- [redacted] had previously had a child taken into care, which could have informed understanding of her own experience of being parented.
- Lack of analysis of [redacted]'s ambiguous relationship with her parents for example: her father accompanying her into the GP consultation regarding a gynaecological complaint; her unwillingness to allow her father to attend the CAF meeting [redacted]; information provided to Early Break about parental alcohol use; negative attitude towards [redacted] and her child.
- [redacted]s periods of homelessness, her relationship with her grandmother and her parents' response.
- Violence from [redacted] brothers towards her.
- Reference to [redacted]'sleeping with her brother'

4.4.26. As well as a lack of reflection on these and a range of other potential concerns, there is evidence that various professionals including social workers, health professionals and YOT staff were inconsistent in following up or checking information. During the course of this Review information has been sought from AuthorityA Children's Social Care in relation to [redacted] but there is no evidence that any such attempts were made during assessments of [redacted]'s needs. The first time the involvement of the family with services in AuthorityA appears to have been challenged with [redacted] is by the Children's Guardian appointed to represent [redacted], evidencing that such a challenge was possible by practitioners, not simply with the benefit of hindsight provided to this Review. Whilst the information provided was not of the most serious nature it did contribute to an understanding of the family functioning and raise questions about the openness and honesty of [redacted] in particular.

4.4.27. It is important here to acknowledge the potential reasons as to why a practitioner from CAFCASS was able to recognise and challenge this issue, when CSC practitioners were not. The nature and function of the Children's Guardian's role was specifically to review the management of a case from Child [redacted]'s perspective with the benefit of all the relevant information collected and working within a very different organisational and legal context. In particular the Children's Guardian was not required to manage the competing pressures of maintaining a relationship with family members in order to achieve improvements. Managing these competing needs over time is recognised as one of the most difficult features of child protection social work and requires skilled practitioners, with manageable workloads and effective supervision. It is clear that one or more of these positive factors were frequently absent providing some explanation for what was in hindsight poor practice.

4.4.28. What is particularly apparent in relation [redacted] is that they often appear to have sought refuge with wider family members, but this was not in fact safe. [redacted] was on a number of occasions turned to both by the family and by Social Workers, for support [redacted] However, given the difficulties apparent within the family as a whole, including conflict between [redacted] and her sisters, it is concerning that there was such limited assessment of her and her husband's suitability until 2008. [redacted] had caused criminal damage at her brother in law's takeaway, information that would have been available to CSC from her previous convictions. The YOT worker at the time was concerned about this offence and believed that there was information that was not being shared, but was unsuccessful in her attempts to find out more from [redacted] and her family.

4.4.29. A viability assessment was undertaken [redacted] in relation to the couple as potential carers for [redacted], the conclusion of which was negative. No information is available as to why this was the case, nor is there evidence that the assessment contributed to further understanding of any of the 3 young people. In 2011 an allegation of sexual assault was made by [redacted] against [redacted]. Whilst this is information based on hindsight and it would be unreasonable to presume that it could have been detected at the time, the lack of any form of assessment represented a missed opportunity to understand the complex dynamics of this family and any risks within it.

4.4.30. It is however the lack of understanding and analysis of the role of AdultD that is of particular concern. It is remarkable that so little professional curiosity was aroused by [redacted] relationship with their uncle. This should have been subject to much more detailed scrutiny not least because of the trickle of worrying information about sexual activity in his house. Moreover it is surprising that there was no evident concern as to why two young teenagers would prefer to live with a relative considerably older than themselves rather than with their own parents. Given the previous history of sexual abuse in the extended family the willingness of the young people's mother to allow them to stay with an older male relative and his teenage/adult sons should have raised alarm. Instead it is recorded by CIT in 2009, and was apparently unchallenged, that [redacted] approved of [redacted] living with AdultD and that it helped "*family dynamics"*.

4.4.31. In each of the families there was also either direct evidence or unresolved questions about the existence of what is often referred to as the "toxic trio" – parental mental health, domestic abuse and substance misuse[34]. Whilst these issues were referenced within several of the assessments undertaken, there is little evidence that they played a part in understanding the young people's overall

[34] Brandon et al 2008 p55 & Cleaver et al (2011), Working Together (2006:156)

experience and the particular risks to children when there is a combination of such problems.

4.4.32. Too often professionals, not least Social Workers, allowed themselves to be reassured by family members that they would protect their children, even when previous reassurances had proved to be ineffective. Reassurances may have been well intentioned, but previous evidence should have alerted professionals to the likelihood that they would not in themselves lead to a change in behaviour by the adults in managing the safety of their children. There were however also several examples of clearly collusive behaviour in particular by the mother of [redacted] for example in providing [redacted] with alcohol and in her approach to her daughters contact with several men, including AdultD.

4.4.33. What has become all too apparent in analysing the approach of agencies to these young people during the time scale of this review is that with the exception of [redacted] there was significant evidence for much more co-ordinated multi-agency involvement in their families at a much earlier stage in their lives. This was also particularly commented on by the mother of [redacted] who believed that they had needed help when the three siblings were much younger.

4.4.34. A number of agencies had information about the young people's lives prior to the timeline, including concerns about the parenting capacity of their parents and significant indicators of neglect from early in these young people's lives. Whilst it would not be reasonable to assume that professionals involved with the young people in their earlier childhood could have anticipated that they particularly would become victims of CSE, there was significant information in these families pointing towards the need for early intervention and planned support and preventative work at a much earlier stage.

4.4.35. What we are able to see with hindsight is that by the point at which agencies did intervene more actively the problems had become increasingly entrenched and the young people's vulnerabilities had been effectively identified by men whose motivation was to exploit them.

Engagement: *"The attitudes and behaviour of individual practitioners have a major effect on whether families engage"*[35]

4.4.36. The absence in several of the social work assessments of any involvement of the young people has already been noted. What is also equally striking however is a similar absence of evidence that many social work staff, particularly those responsible for case management really knew the young people as individuals or had been

[35] Fauth et al C4EO Safeguarding Knowledge Review 2010

successful in establishing a meaningful working relationship with them over the longer term.

4.4.37. Assuming that recordings accurately represent the actions of practitioners, it would appear that CSC staff with direct responsibility for assessment or case management often had a minimal level of contact with the young people. What can instead be seen is a pattern of home visiting being undertaken by others, such as family support workers or Out of Hours teams and at times lengthy gaps where no direct contact with the young person took place. This approach reflects an organisational structure established over years within Children's Social Care. This structure was designed to use support teams, providing short term task centred inputs, teams which had initially been developed to provide early help and short term task centred work. However, a clear pattern that has emerged, in common with other recent Serious Case Reviews in Rochdale is that teams such as the Family Support Team or the Out of Hours team were in practice being used to prop up overwhelmed duty and assessment teams – colloquially the 'front door' of Children's Social Care.

4.4.38. Whilst a team approach clearly does have a legitimate place, the consequence here too frequently was a lack of any effective personal engagement between the key Social Worker and the young person leading to distrust, ineffective intervention and at times direct hostility, a pattern which is likely to have become self-perpetuating both for the young person and the practitioner. There is no evidence that Social workers adopted a conscious case management approach or understood the risks to their personal relationship with the young people and their families. More importantly there is no evidence that they were encouraged to do so by their immediate managers, and on the contrary the service design supported this approach.

4.4.39. Records evidence little sense that the key Social Workers were able to work alongside the young people, that they were able to empathise with them or connect with them in any meaningful way. Working with adolescents requires differences in approach to working with young children; issues of respect and trust are of crucial importance and take time and commitment to build. Whilst the time available to the Social Workers concerned will undoubtedly have been very limited, there were nevertheless missed opportunities to engage and no evidence of creative practice. Home visits as recorded frequently reference little or no discussion with the young people themselves, there is rarely evidence that the young people were seen alone or in environments where they might feel more at ease.

4.4.40. In the case of [redacted] for example it is apparent that routine practice was to visit only on the day of a Core Group or Child Protection Conference, giving the impression that the priority was to meet statutory minimum requirements at times suitable to professionals rather than considering what might achieve the best response from the young person. There is little to suggest that serious attempts were made to engage the young people in the Child Protection

meetings, rather there appears to simply be an acceptance that they will not attend.

4.4.41. Whatever the strengths and weaknesses of individual practitioners, the general lack of relationship building must be seen in the context of wider workloads and the expectations of both practice management and strategic leadership. Building relationships with young people is time consuming and requires commitment from a senior level in order for practitioners to be able to prioritise such an approach. What has been stated quite explicitly on a number of occasions within this Review is that in the context of the resources available, the priority for the department was in relation to babies and young children, not adolescents. In this context it is not perhaps surprising that time spent building relationships with 'difficult' teenagers was not a priority, particularly when those teenagers themselves had babies who needed protecting.

4.4.42. However it is important to record that as with other professionals quite a mixed picture emerges, with some workers showing signs of persistence in their attempts at engagement even in the face of at times quite difficult, openly negative responses from the young people. Some workers from both the CSC family support team and from the Young Person's support team in particular showed such persistence, in one case despite having received threats from the young person concerned. A particularly positive view regarding the specialist Sunrise Social Worker has been stated within the CSC IMR and by others. In the absence of information directly from the individual, his manager or feedback from the young people, it is difficult to assess what enabled this Social Worker to be more effective in his engagement but may well have included:

- specialist role allowing skill development with client group
- dedicated time and resources
- Individual skills of the practitioner
- active seeking out of the young person and their family

It is reported that the individual left in frustration at the role being diluted and the short time that he was in post means that an analysis of the components of success is difficult to achieve. It is also difficult to know what the longer term outcomes would have been. However, research in relation to young people's views of social workers and professionals provides a clear picture of what young people seek ""*someone who is friendly, nice, funny and respectful…someone they could rely on*"[36]

4.4.43. It has also been noted that other professionals had very mixed success in establishing meaningful engagement with the young people and evidenced differing amounts of effort in trying to achieve

[36] Rees et al (2011:65)

engagement. The potential strengths of the voluntary sector in working with this age group were reflected in Early Break's greater success in developing trust and maintaining relationships over time. Early Break workers demonstrated a degree of persistence despite experiencing not infrequent rejection by the young people. Practitioners were consciously aware that when young people pushed them away this might be part of testing them out rather than a permanent refusal to engage. This was not to say that Early Break demonstrated a perfect model of success, but for example with [redacted] their approach led to her seeking their help at a time when she felt able to do so.

4.4.44. The Social Worker's role by its very nature can create a barrier with a young person and one approach is to work closely with the young person and a professional with whom they have established a trusting relationship. It is unfortunate that this approach was not adopted more routinely in these cases, and indeed that there appeared to be something of a hierarchical approach presented by some CSC staff. This was evidenced most explicitly when [redacted] was instructed to move from Early Break to the adult substance misuse service without any discussion between the Social Worker, [redacted] and Early Break as to how this would affect [redacted]'s work with Early Break. [redacted]'s subsequent comments to the Early Break worker powerfully reflect her sense of having no control of the decisions being made about her and give an insight into the limited nature of her relationship with her Social Workers. What is commendable is that the Early Break worker supported [redacted] in this change of service provision despite their misgivings.

4.4.45. Not only did distant this style of working create the conditions for a poor relationship between Social Workers and the young people, it also limited the capacity of social workers to observe and understand the young people within their families which could have led not only to a more trusting relationship but also to a recognition that significant neglect was a feature in their lives. "*Being in a position to observe and witness the parent–child relationship directly enables an experienced worker to gauge the presence of disorganised attachment behaviours which are linked, according to two robust review studies, to both family risk factors and child maltreatment*"[37]

4.4.46. There were other examples of positive and age appropriate engagement with the young people including:

- support provided to [redacted] by CIT after her child was removed, including providing advice about legal representation.
- Positive feedback by [redacted] about her relationship with Connexions staff and CIT
- CIT2 supporting [redacted] during video interviews

[37] C4EO (2010:11)

- Positive relationship with PC6 during Operation span
- Persistence and concern demonstrated by school health practitioners.
- Connexions worker supporting [redacted] to attend an interview at the college
- Positive encouragement by GP to [redacted] attend alcohol and mental health services

4.4.47. The YOT IMR identifies that [redacted]s engagement with their service was 'very good'. However there is no definition of 'very good' and how this conclusion has been reached. There is a noticeable absence of any 'picture' of [redacted] which would demonstrate that her personality, wishes and feelings were known and considered significantly by the organisation. In the absence of this information the Review would challenge the YOT service as to what constitutes meaningful engagement with the young people it works with. The analysis provided by the YOT IMR is very focussed on national standards, policy and procedure with considerably less analysis on the effectiveness of direct work with the young people. As has previously been noted reflecting national policy expectations. Discussion with the current Service Manager suggests that there has been in recent years a significant focus on 'compliance' with and completion of orders and it may be that this focus has been to the detriment of developing a culture of meaningful engagement or a focus on outcomes.

4.4.48. What is apparent from the actions of professionals who achieved the greatest success with the young people was their persistence, a more creative approach than offering formal appointments and an active approach to following up missed appointments. The key issue of persistence in working with those who may be viewed as 'difficult to engage' is reflected in lessons from a previous SCR prepared by the same author for Rochdale SCR (A,B, C)

4.4.49. There is little doubt that all the young people will have challenged professional capacity and at times patience. Child protection work is by its nature emotionally draining, can be difficult and at times dangerous. The nature of the young people's experiences did not lead to them being easy to form relationships with. However, the very reasons that will at times have made them difficult to work with, were the reasons that professionals needed to try particularly hard to attempt to engage with them. What was needed was the ability to see past the "challenging behaviour" as to why these young people were behaving in ways which were damaging to themselves and at times to others.

Understanding the young people's behaviour

4.4.50. Whilst we have limited information about the young people's personalities, their expectations of themselves, their hopes, aspirations, and strengths, a very striking picture has been presented across agencies of the behavioural challenges they posed both to themselves and others. This picture is one that has been identified across a number of Serious Case Reviews "*agencies focused on the young person's challenging behaviour, seeing them as hard to reach…rather than trying to understand the causes of the behaviour and the need for sustained support*"[38]. Recorded comments by some of the professionals displayed a level of frustration with the young people and their families which at times appeared negative and judgemental. One particular example is the response of a Social Worker to another professional's concerns about [redacted] that *"CSC had been there before on several occasions and it had not made a difference*". Had professionals understood both that the young women were subject to serial exploitation and the impact of this exploitation upon them, it is possible that a less skewed picture of their behaviour might have emerged.

4.4.51. The young people often exhibited ambiguous behaviour towards the men who were abusing them: frequently returning to them, repeating patterns of behaviour; being unwilling to engage with the police or other authorities; appearing inconsistent in their accounts. One small, but powerful illustration of this is an occasion in 2009 when [redacted] was seen on CCTV stroking the face of a man who she later said had kidnapped and sexually assaulted her. It was exactly such actions as this that tended to lead to judgements about the young people's credibility and on this occasion it was considered to be a false allegation. Whilst it is not possible to know the truth of this particular incident, what we now know about the way young people adapt to being abused would tell us that this behaviour does not in itself rule out the possibility that [redacted] was subject to abuse by the man concerned.

4.4.52. The impact of early trauma in young children's lives is increasingly well understood through research and the development of Attachment Theory. What practitioners were clearly much less able to recognise was the impact of trauma on the behaviour of this group of adolescents. Basic child development theories should have to some degree alerted at least some of the professionals to the difficulties the young people would be facing by the very nature of moving from childhood to adulthood. Similarly applying a good knowledge of child development would have helped contextualise some of the behaviour – for example that a problem in adolescence can be understood as a reflection of a "*well-established pattern of family communication rather than simple a symptom of adolescence itself*. [39]

[38] OFSTED, Oct 2011
[39] Daniel et al, 2010

4.4.53. However, there are a number of examples when the approach of professionals started from a very particular adult context which presumed the young people should have an understanding of complex situations in the way that they were seen by the professionals. One example of this is a Social Work assessment which refers to [redacted]: "*failure to see the seriousness of becoming pregnant at 13 years old* ". This represents a significant absence of understanding and analysis as to the implications of her real age, her developmental age, her personal experience or her learning difficulties, instead viewing her response simply as a failure to take her situation seriously.

4.4.54. Whilst clearly not all the professionals involved with these young people could be expected to have a strong grounding in the relevant research, children's Social Workers and those whose primary client group was young people, for example the YOT team, CAMHS, educational staff, should be expected to have some underpinning knowledge as well as access to training and information about key messages from research. Whilst clearly this must have been the case for some workers, the overall impression is that there was limited knowledge across many of the services and no evidence that research or practice based information was, for example, drawn on in supervision or other case discussion. No direct information has been provided about the existence of a sound practice knowledge base with regards to child development for this age group and this is an area for future development.

Multi-agency recommendation 5

4.4.55. There is now a growing body of research and knowledge on the impact of trauma as it relates to the victims of sexual abuse, knowledge which would have been unfamiliar to most staff at the time and which is only now becoming more widely understood. Access to this knowledge had it been available would have offered practitioners a different way of understanding the young people's behaviour. Such an understanding could in turn have led to more effective interventions and assessment of how to work with the young people to improve their safety.

4.4.56. The research identifies that in order to survive traumatic experiences behaviour which appears contradictory and difficult to understand may be exhibited by the victims. The phenomenon can result in the victim *"experiencing positive feelings toward their victimizer, negative feelings toward potential rescuers, and an inability to engage in behaviours that will assist detachment or release"*[40] Other common responses include: "revictimization*, self-injurious and self-harming behaviours and externalizing the trauma by victimizing others"*[41]. With the benefit of hindsight these are powerfully accurate depictions of the behaviour displayed by the young people and a crucial lesson for

[40] Lodrick (2007) quoting Carnes, 1997
[41] Lodrick (2007) quoting van der Kolk & McFarlane, 1996

services in Rochdale is to integrate this knowledge into working practice.

4.4.57. This research base also provides a very particular insight into the experience of [redacted] and other young people who have been abused and themselves become complicit or active in the abuse of others. All the young people needed to find ways to survive, both practically and emotionally, within this dysfunctional world where they were repeatedly being abused. Practical and safe options for young people who cannot live within their own families are very limited, as the often unsuccessful attempts by housing staff to find some of the young people accommodation demonstrates. Where young people's education has been disrupted, they are less likely to have employment and therefore a means of sustaining themselves economically. There may be nowhere in their family or friendship network that provides a safe haven. One means of survival for some young people is to protect themselves by aligning with the abusers.

4.4.58. The experience of those working directly with these and other young people was that those who did become a contributor to the abuse struggled to understand their own behaviour, a struggle mirrored in the reactions of professionals, such as police officers, who simultaneously had to work with young people both as victims and potential abusers. This response adds further complexity to the task of working with these young people and requires sensitive and careful support by agencies of those involved in the work. In developing policy and practice with regard to CSE, the Board should include consideration of the support needs of staff working in this field.

4.4.59. A further common theme amongst agency responses which demonstrated the lack of understanding as to the nature of child sexual exploitation was a focus not on their vulnerability but their 'high risk' behaviour. There are repeated comments made to and about the young people based on a view that it was within their power to *'keep themselves safe*'. A similar frequently made comment was in relation to the young people '*engaging in risky behaviour'*, suggesting that this was something they could chose not to do. Research tells us that there is a tendency to presume that young people are more in control of their worlds than is actually the case and that professionals are less likely to recognise when young people are at risk.[42] This is a presumption that young people then internalise.

4.4.60. The young people were frequently advised about the need to take responsibility for their actions, to protect themselves, to stop certain behaviours. However it is apparent that much of the time the young people did not view themselves as being at risk and often appeared to believe they were in control of the situation themselves. For all these reasons an approach which instructs young people to remove themselves from the danger is reminiscent of some similar responses

[42] Rees (2011)

to the victims of Domestic Violence and is unlikely to be effective as it fails to recognise the power dynamic of the abusive behaviour, the victims' adaptive behaviour as a survival mechanism and their actual level of control over the world they inhabit.

4.4.61. What was required and was not within the power of individual practitioners was a complex multi-agency approach, including disruption techniques, prosecutions and intensive packages of support.

4.5 The operational response: The effectiveness of multi-agency working.

4.5.1. The effectiveness of multi-agency interventions with the young people, including management of child protection plans, will be examined in section 4.6. However, the wider picture of the functioning of multi-agency working merits separate analysis.

4.5.2. The expectation that agencies work together in order to safeguard children has long been established as a fundamental requirement of good practice embedded within statutory policy and guidance and underpinned by evidence.[43] However, problems in multi-agency working remain a repeating feature for criticism and have been found to represent the most frequent recommendation in Serious Case Reviews.[44] The quality and effectiveness of relationships between agencies fundamentally affects the provision of services intended to safeguard children. Achieving good quality multi-agency working is a "*skilful and challenging activity involving considerable demands at both practice and policy levels…enhancing service provision when done well…frustrating and disempowering when delivered ineffectively".*[45] On the evidence of this Serious Case Review this experience is mirrored in Rochdale.

4.5.3. Relationships and partnership working between the agencies at an operational level reflected many of the same problems that have been highlighted at the strategic level. Operationally, there is evidence of good communication and good partnership working, however, this was inconsistent and partial, with agencies too often failing to share information in a timely way or working together effectively. The result was a patchwork of good practice interspersed with significant gaps. These problems can be seen amongst and between different agencies, although some particular trends emerge. Examples of the gaps include:

[43] Davies and Ward (2012:136)
[44] Brandon et al (2011: 2)
[45] Family Policy Alliance 2005, quoted in Morris (2008:1)

- Pupil Referral Unit sharing information with Connexions regarding [redacted]s pregnancy CSE involvement but with no evidence that they then sought information as to the outcome.
- Lack of co-ordinated approach towards information sharing with other agencies by Education Staff at the Learning Centre attended by [redacted] Identified as a result of not having a designated Child Protection lead in the school.
- Absence of proactive information sharing by CAMHS with other agencies
- Absence of information exchange between CSC and YOT regarding [redacted]'s offending in [redacted]
- GP not informing CSC of referral for [redacted] to mental health services in [redacted]
- Sunrise team reporting concerns to LSCB about schools but not sharing this with the schools themselves.
- [redacted] CIT wrote to a GP with concerns about one of the young people, but there is no information that they had referred to CSC

4.5.4. There has been a consistent comment made by several of the agencies that they were excluded from information by Children's Social Care and by other 'key agencies'. It is not always clear to whom the latter refers but would appear to include the police, CIT and the Sunrise Team. It is a positive outcome from this Review that these frustrations have led during to significant reflection by some of those agencies regarding the way in which they were able to assert their role in the multi-agency partnership, including for example in relation to escalating concerns. Early Break for example has produced 2 related recommendations as a result.

4.5.5. Irrespective of the part played by other agencies there is supporting evidence of poor information sharing and inter-agency liaison by CSC at a level of frequency which suggests that this was indeed part of a wider feature of that agency's approach to multi-agency working. Examples include:

- Lack of information sharing from CSC to CIT regarding decision to remove [redacted]s child
- Relevant practitioners not being informed of, or invited to, LAC reviews regarding [redacted]s child
- Social workers not returning calls even when urgent messages left.
- Social Worker refusal to speak to CIT in February 2009 regarding [redacted] on the basis the case had been closed.
- CSC unilaterally insisting on a change of Alcohol service provider for [redacted]
- Information about [redacted]s child being in foster care not being shared by CSC with CIT.

4.5.6. The experience of some practitioners and agencies was that they were treated in a peremptory and dismissive fashion by children's Social Workers and that there existed within Children's Social Care a culture of not valuing other organisations, especially but not exclusively the third sector. As a number of the key CSC practitioners involved in these incidents are either no longer working for the authority or were subject to other internal procedures, it was not possible for the IMR author to explore with them their perspective on how they responded to other agencies limiting our capacity to understand what was happening at the time.

4.5.7. Nevertheless, some of the examples provided do suggest that some Social Workers presumed 'seniority' over other partners and asserted this in a fashion which did little to develop positive working relationships. Both good multi-agency work and effective intervention with families rely on strong inter personal skills not least from social Workers who are recognised as having a key role in enabling the partnership to work. It is therefore of concern that a number of professionals have been left with a significantly negative experience of Children's Social Care practitioners. Understanding why this happened in relation to individual Social Workers is of less value in improving future practice than understanding why it went unchallenged by either frontline managers or by senior management. Team managers should reasonably be expected to have known the culture of their immediate working environments and personal styles of practitioners within their teams. If this was not the case it suggests there was an absence of focus within the organisation on the environmental factors that will support practitioners in achieving good practice. It is further indicative of the culture at a senior management level within Children's Social Care that Early Break experienced a failure to respond even when challenges were made at a senior management level, leaving them feeling that there was no further action they could take.

4.5.8. Although direct information from practitioners is limited, there is evidence of other factors which impacted on the inter-agency difficulties at the time. A key issue which appears to have created barriers was the absence of any protocol as to what information should be shared when child sexual exploitation was under investigation. The Youth Service for example identified that there was a lack of any clear processes for reporting or sharing *"non-referral intelligence and information around CSE"* until 2012. This has been identified by several of the agencies as creating a barrier to information sharing.

4.5.9. It is known that on least one occasion CITC was unwilling to share information with Police and Children's Social Care. This was on the basis of '*client confidentiality*' in that CITC did not feel it should be shared without the individual's consent, but was also due to concern that it might result in a direct approach by the police, leaving the

young person at risk. This resulted in a direct instruction from the named nurse and Director of Delivery that the information should be shared, but clearly leaves open the unanswered question as to whether and to what extent this had occurred on other occasions. On another occasion at a multi-agency strategy meeting minutes produced by the Police were recalled and agencies told they should not be saved or used.

4.5.10. Other problems arose as a result of the knowledge base of a number of individuals, particularly those in roles which might not have provided them with the opportunity for safeguarding training. Particular examples included Greater Manchester Police CID officers; social work trainees and some YOT staff without relevant professional qualifications. This highlights the importance of putting in place a means to ensure that all such staff are supported in understanding and dealing with safeguarding requirements, whether by specific training, mentoring or other forms of supervision and management oversight. A multi-agency recommendation has been made which addresses this gap.

Multi-agency Challenge 3

4.5.11. Where good communication across agencies was apparent this was often a consequence of relationships between individuals, rather than due to systemically embedded agency relationships or culture. Rochdale Borough Housing in particular has reflected that there was a lack of good 'structured' relationships with other key agencies, such as CSC and a reliance on ad hoc links between individuals. Housing staff interviewed felt that where there was good communication for example it was '*based on personal relationships between officers rather than being an organisational priority*." Another example is described by Early Break who identified a particularly helpful relationship with a police officer PC6 and there is clear evidence within this review of this officer actively working with others. Good personal relationships can undoubtedly strengthen multi-agency work However, reliance on personal relationships as the predominant means for achieving communication creates vulnerabilities.

4.5.12. In complex work environments staff, particularly when they are under pressure, may take short cuts to achieve a particular goal. The disadvantage of the reliance on personal relationships is that it leads to a risk that professionals use their personal judgement as to how and with whom they should raise concerns, which may or may not lead to the right outcome. Formal child protection systems are intended to be, transparent and accountable, with good working relationships supporting those systems, rather than replacing them. What appears to have been lacking however, was any wider reflection on the effectiveness in practice of the systems in place or any means for identifying warning signs of weakness in the way the system was working.

4.5.13. Conversely by identifying some of the good practice examples it is possible to see particular features that supported good practice:

- August 2010 – Connexions sharing information with all known relevant agencies regarding the links between [redacted] Practitioner supported by clear supervision and management oversight.
- Routine sharing of information between A&E and GP services: supported by established recognised processes.
- Joint meetings with various professionals and [redacted]

4.5.14. Problems within multi-agency working however, were not limited to relationships and communication. There is additionally a significant thread of information running through the agencies responses to the young people regarding at times very poor compliance with basic Child Protection and safeguarding procedures. What is of significant concern is that the poor implementation of child protection processes and the absence of effective adherence to the Board's procedures clearly impacted not only on the individual service received by the young people, but also on the capacity of agencies to make links between them and learn from their experience.

4.5.15. LSCB procedures are designed to enable all agencies to understand their roles in multi-agency safeguarding and are the cornerstone of child protection. It has been identified, not least in the Children's Social Care IMR that there were a worrying number of occasions when it is clear that both social workers and their front line managers failed to work to their own procedures. This involved a number of different occasions, suggesting that there were both weaknesses in individual practice, but also key failures in the working of systems designed to provide checks and balances and included:

- strategy meetings not arranged for [redacted] in 2008
- a manager 'logging' concerns about CSE for [redacted] rather than ensuring they were investigated.
- Lack of response to referrals eg by SchoolD in [redacted]

4.5.16. The reasons for individual gaps in practice standards are not always easy to ascertain, but there are a number of factors that repeatedly emerge. It has been identified for example that the Multi-agency procedures had only just been published in May 2007 and therefore were not fully embedded. However, as these examples and others relate to core functions of children's social work this can only be considered a partial explanation.

4.5.17. In 2009 an unannounced OFSTED inspection of the Contact, Referral and Assessment arrangements identified a number of problems including:

- Thresholds not being fully understood by partner agencies.
- Variable quality of Initial and Core Assessments

- Lack of systematic recording of children's views
- Poor record keeping
- Supervision falling below agency standards

These findings are entirely reflected when considering the service provided to YP1-6, confirming again that problems were not case specific but part of a much wider problem within Children's Services.

4.5.18. Weaknesses in adhering to agency and Board Child Protection procedures can also be seen across other agencies. Whilst there are a range of examples, a number of repeating patterns can be detected. In common with many other Serious Case Reviews, it is apparent that there were problems with the understanding by other agencies of the thresholds for referral to Children's Social Care. Action for Children is explicit in their view that thresholds for referrals were high, which is clearly born out when considering the response to these young people.

4.5.19. Comment has already been made about a theme of professionals and agencies failing to recognise that the young people were at serious risk which should have led to a Child Protection referral. It should be noted that many of the agencies did make various appropriate referrals to Children's Social Care in relation to these young people during this time period. However, there were also other occasions when there were professional concerns about the young people which it might have been anticipated would have led to a referral or other contact with CSC, but this did not take place These included:

- [redacted] School Health practitioner noting 8th incidence of domestic abuse in relation to [redacted]. Information not forwarded to CSC
- [redacted] Health visitor informing YOT about [redacted] possible pregnancy and concerns about her capacity to look after a child. No record of referral to CSC
- [redacted] No contact by school with CSC following evidence of [redacted] self-harming and with suicidal thoughts.
- [redacted] letter from 'psychiatric services' to GP [redacted] outlining a considerable number of problems within the family which were impacting on [redacted] mental health.
- [redacted]: concerns noted by CSC about the late sharing of information by CIT

4.5.20. A related pattern emerges by which agencies when they do refer the young people request 'family support' from Children's Social Care rather than making a formal safeguarding referral:

- May 2007 HV refers [redacted] for family support
- [redacted] Midwife completes a Special Circumstances Form listing a range of concerns and refers [redacted] for family support

- [redacted] Housing officer makes a referral for Family Support

4.5.21. Whilst understanding each event individually has not been practically possible given the passage of time and the methodology used by this type of Review, there are nevertheless some possible explanations as to why agencies operated in this way. The narrative outlined in this Review evidences a pattern of CSC not responding to the referrals as safeguarding and agencies subsequently not referring further concerns. The frustration of the referring agencies is often very apparent and it has been noted by agencies that this resulted in them not referring again in the future. National research has drawn attention to a recurring theme whereby agencies in particular schools, GPs and other health workers, do not make referrals to CSC due to low expectations of what will be achieved combined with the perceived damage making a referral can cause to their ongoing engagement with families. [46] A specific example of this is recorded by CIT who noted that disclosing information about [redacted] might lead to her disengaging from services.

4.5.22. There was no evidence of any established process or culture whereby agencies could seek advice and support from Children's Social Care as to how to respond to concerns, to discuss whether the issue of concern was likely to meet statutory thresholds or consider alternative ways of responding, such as the use of a CAF. On the one occasion when a Social Worker did suggest a CAF (August 2010 regarding [redacted]) this clearly failed to recognise the Young Person's safeguarding needs and in any event led following the CAF meeting to a referral for an Initial Assessment. Action for Children specifically notes that its staff perceived thresholds in CSC to be high and concludes that this may have been a reason why they did not refer on some occasions when with hindsight it would have appeared the right course of action. Where agencies are unclear about the thresholds for referral, or perceive that thresholds are too high, this conscious or unconscious decision not to refer again is likely to become one of the ways in which agencies respond.

4.5.23. An area of particular concern is the frequency of non-compliance by the Crisis Intervention Team in working to the Board's Child Protection Procedures and the absence of a fundamental understanding of their role in working as part of a partnership. CIT stood out as having been the first service to recognise explicitly that the young people were being exploited and that this was placing them at significant harm. This team clearly played a crucial role in identifying CSE and in supporting young people. However the serious gaps in their partnership working ultimately contributed to the collective failure to meet these young people's needs.

4.5.24. A particular problem was CIT's approach to making referrals and contacting Children's Social Care which led to considerable confusion.

[46] Davies and Ward (2012:47)

CITC has given evidence to the Home Affairs Select Committee that the team had made 103 referrals to CSC as well as 181 'alerts' in relation to these and other young people. Pennine Care as a result undertook a validation exercise consisting of a full audit of all information that was shared by the team. CITC's evidence and the subsequent audit refers to all the young people the team worked with, not only to YP1-6.

4.5.25. The audit defined a referral as one of the following:

- a Multi-agency referral form
- a communication by phone (verified by an entry in the case note); letter or fax termed "Referral" or the inclusion of an expression of absolute vulnerability to sexual exploitation.

An 'alert' was defined as:

- a telephone call sharing additional concerns or intelligence in relation to a previously known subject
- a communication by letter or fax documenting intelligence or sharing additional concerns.

4.5.26. The conclusion of the Pennine Care analysis was that overall approximately half the number of referrals stated were actually made to Rochdale Borough Council (ie Children's Social Care or the Safeguarding Children Board) and approximately one third of the alerts as stated. The analysis also '*identified a significant number of instances when a disclosure by a client was of such concern that it should have been formally referred in line with the multi-agency safeguarding procedures however the author cannot find any evidence of any such referral.*" This picture is replicated in relation to the young people subject of this Review. The audit specifically analysed the referrals and alerts made by CIT purely in relation to the 6 young people subject to this Review .There were a total of two referrals to the police and 4 referrals to Children Social Care. This analysis is congruent with the information provided to this Review

4.5.27. The referrals to CSC and the police were as follows:

- February 2006, [redacted]: referral to CSC following concerns regarding vulnerability to sexual exploitation (not clear exactly what was stated)
- Sept 2007, [redacted]: referral to CSC for Family Support.
- May 2008 [redacted] referral to CSC re domestic violence and threats from father of [redacted] unborn child
- August 2008 [redacted] referral to CSC and to the police following disclosures that [redacted] was sleeping with multiple 'older Asian men'
- January 2009 [redacted] statement of disclosures by [redacted] forwarded to police and CSC

- August 2010 [redacted]: unclear, appears to be liaison with police regarding the making of a statement by [redacted]

4.5.28. There is an evident disparity between the numbers of referrals that CITC believed the team had made and the number actually made. This can in part be explained by a practice of sending letters to a range of people and teams within Children's Social Care and also to the Board, who did not have a function in safeguarding individual children. Some letters were addressed '*To Whom it May Concern*' rather than to a named person and there is, for example, no evidence that letters were actually received by the Safeguarding Board. Undoubtedly a letter clearly identified as a referral should have been forwarded to the Duty and Assessment team for action, irrespective of where it was first received within Children's Social Care. But the method of communication means that subsequently there is no clear audit trail of communications and information sharing or any mechanism to follow up actions. It is also apparent it was often not evident to the recipient of the information that it was intended as a formal referral.

4.5.29. This presents a much more confused picture than has previously been placed in the public domain. Referrals were made by CIT in relation to three of these young people. The rate of referral was on average once a year, which quantitatively would not be considered unusual. Nevertheless it is also the case that CIT regularly spoke to a range of agencies, including CSC about their concerns for the young people. They also produced written reports within various processes such as Child Protection proceedings. This analysis therefore does not deny that they spoke out about their concerns or that these should have been taken much more seriously by Children's Social Care in particular. However, it provides a quite different view on the way that CIT sometimes worked outside the safeguarding process, their effectiveness in making themselves heard and the clarity about what action they felt was required.

4.5.30. Other problematic practice included:

- CIT staff gathering information themselves about the activities of perpetrators rather than passing this immediately to the relevant agencies, particularly police and children's social care (see July 2008 response to [redacted]
- Lack of referral to CSC or police in relation to 13 year old [redacted] regarding under age sexual activity. Name of uncle attending with her not recorded.
- Lack of effective record keeping, use of tools such as genograms eg no connection was made between two of the siblings who had been referred and disclosed underage sexual activity within a short period.

4.5.31. It has also been identified explicitly within the Pennine Care IMR, and is reflected within other agencies' responses, that CIT staff were seen as the experts on CSE both by themselves and by others. CIT staff

are described by Pennine Care as "*considering themselves as 'sexual exploitation workers' rather than 'sexual health workers'*. This was a misunderstanding of the CIT's role and individual practitioners' qualifications. CIT was commissioned to address the issue of high levels of teenage pregnancy and sexually transmitted infection, as part of the national drive to reduce both of these in young people. They were commissioned to work with vulnerable young people, but not to provide a specialist service to the victims of sexual exploitation. Whilst CIT workers had clearly gained some valuable practice experience of working with the victims of CSE, they had no specialist qualifications and had received no specialist training.

4.5.32. Of greater concern was that the team operated almost wholly outside of any managerial oversight and appeared content to work in this way. The Trust has been unable to confirm that Team members had any Safeguarding training and, it is known, for example, that they were not included in briefings regarding the launch of a Multi-Agency Referral form in 2009 and were not instructed to use it for a further 9 months. The Trust's focus at this time was on multi-agency safeguarding training for Health visitors and school nurses and CIT was not prioritised. Whilst the CIT co-ordinator was rightly critical of this, there is no evidence that she or other members of the team asked for training when they knew that other teams were receiving it.

4.5.33. Neither did the team receive any formal supervision, although CITC provided oversight and direction to team members and ad hoc advice was sought from the Named Nurse. At that time Trust policy was that safeguarding supervision was only provided to School Health Practitioners and Health Visitors. Some conversations took place between the CIT co-ordinator and the Named Nurse regarding safeguarding, but there is no record of these discussions and the experience of the Named Nurse was that the CIT co-ordinator was resistant to offers of supervision. This has been further confirmed within the Pennine Care IMR which stated that the Co-ordinator made it clear in interview for this Review that she "*holds the view that the benefits of supervision would have been questionable, given her expressed perception that the organisational experts on CSE were the Crisis Intervention Team alone".*

4.5.34. What is now apparent is that there was a fundamental mismatch between the views of the Crisis Intervention Team as to their role and the understanding of the commissioners of how this had been developed. "*The significant role that this service was to make in the recognition and response to child sexual exploitation was not envisaged. This continued to go unrecognised by strategic leads as the information was not escalated to them by any of the services.* (Health Overview report). What is revealed is a crucial absence of management involvement in the working of this team, combined with a team culture of strong self-belief and of resistance to inclusion within many of the organisational processes resulting in a practice model

which was contradictory and not subject to challenge. The style of the CIT Co-ordinator was not experienced as inclusive by many of the agencies and the outcome was that some of the important information held by the team did not impact effectively either with colleague practitioners or at a strategic level.

4.5.35. Another gap in effective partnership working that has been highlighted in this Review relate to the expectations which existed between those agencies who refer to services and those agencies who receive referrals in regards to what action will be taken. In the context of multi-agency safeguarding there is a responsibility on both parties to share responsibility for ensuring that referrals are properly processed. However on a number of occasions this process did not work effectively most notably when referrals were made to CAMHS by non-health agencies. CAMHS practice was, and it is understood still is, to assume that the referrer will "*support*" the referral. This is not an unreasonable expectation as it avoids the use of referral on as means for agencies to abdicate their own responsibility. From a more positive perspective, shared responsibility can increase the likelihood of appointments being kept, which is particularly important when referring to a specialist and high demand agency such as mental health services.

4.5.36. What is apparent however is that whilst there is evidence of some joint working, CAMHS on a number of occasions did not provide information to the referrer either about whether the referral had been processed or alternatively whether appointments were being kept. Referrers therefore were often not aware that their support was required, with schools in particular frustrated to discover that a case had been closed due to lack of attendance when they may have been able to support engagement had they known of the problems. Referrals were made to CAMHS regarding [redacted] from different agencies including schools, the Police and GPs. However, information was often not provided to the referrer as to the outcome, or whether the Young Person failed to keep appointments until the point that a decision had been made to close the case (with the exception of the GPs). Because of a lack of information provided by CAMHS this Review has been significantly reliant on information provided by other agencies. It is not clear if there is any explicit agreed protocol between CAMHS and other agencies in this regard, and if so how such a protocol takes into account safeguarding issues

4.5.37. This therefore raises a question as to whether all agencies accept they have shared responsibility when referrals are made. It would be reasonably anticipated that the young people subject to this Review might not respond consistently, if at all, to formal appointments being offered. There were some practitioners who were in a position to support and encourage their engagement with CAMHS, for example the School Health Practitioners. What appears to have been lacking is a shared commitment to achieving this, possibly as a result of a

defensive decision by CAMHS as to how to manage its resources. If this is the explanation, it is not in keeping with the requirement to contribute to safeguarding as a partnership. The result in the cases of these young people was considerable confusion and frustration between agencies, lack of a clear route for information sharing with appropriate safeguards for confidentiality, and possibly a failure to engage the young people with a key service. Given these unanswered questions both Pennine Care and the Board will need to satisfy themselves that basic Child Protection requirements are being met in the work of CAMHS.

Multi-Agency Recommendation 3

4.5.38. A mixed picture of the effectiveness of multi-agency working by the GPs involved is also apparent and reflects experience common across Serious Case Reviews and other analyses of multi-agency working. The IMR for the GP Service has identified that in the early stages covered by this review there was a lack of knowledge about child sexual exploitation and a lack of clarity about the role of the GP in child protection and safeguarding. Although there is a range of evidence about liaison by GPs with other health professionals, there is no evidence of direct involvement of GPs in Child Protection procedures. Whilst it is recognised that there are real practical difficulties for GPs in attending CP conferences, there is also a lack of consistent information sharing beyond the health family. There is evidence that a GP shared share some information with the Social Worker, but it is difficult to detect a clear auditable path of information exchange leaving open the possibility that information which should have been passed on was missed.

4.5.39. **Conclusion:** The familiar, nationally experienced, disparity between the universal acceptance of the theory of multi-agency working and the evident difficulties in achieving it in practice are reflected in the organisational and the strategic practice in Rochdale as illustrated in this report. The picture of multi-agency working across the services as experienced by these 6 young people suggests the need for a comprehensive reappraisal at Board level of how this is managed locally rather than a reactive 'bolting on' of further training, policies or other safeguards. It is the view of the author of this report that without a radical reappraisal of the way agencies in Rochdale work together, individual policy or practice improvements, however well considered, ultimately risk failure if these are not underpinned by a shared and active commitment to making multi-agency working a reality at a strategic level.

Multi-Agency Recommendation 2

4.6 The operational response: The effectiveness of intervention

4.6.1. A considerable proportion of agency involvement with the young people involved responding to referrals and making assessments. But the young people were also in receipt of a range of services and interventions with differing degrees of effectiveness. As with the process of recognition, assessment and engagement, services provided cannot simply be dismissed as inadequate. There is evidence in a number of agencies that services were provided which were positive, met agency standards and showed a determination to try to help the young people and meet their needs. However, the quality of intervention was very variable and overall was often ineffective.

4.6.2. Each of the agencies has reviewed its individual actions and identified recommendations for learning (see Section 6). It is not the intention of this Section to consider all 17 agencies individually, but rather to consider patterns across the agencies and how they did or did not work together in providing services to the young people.

4.6.3. It is apparent from this Review that there were numerous opportunities for agencies to intervene throughout the young people's lives. The quality of assessments undertaken in response to referrals, the lack of understanding of Child Sexual Exploitation as a child protection issue, rather than just a concern for the Police and the lack of recognition of the safeguarding needs of adolescents meant that the young people were frequently not recognised as being at risk of significant harm. There was evidence on a number of occasions and in relation to many of the agencies that the young people should have met the threshold of a risk of significant harm and yet only two of them, [redacted] were subject to child protection planning throughout the 5 years covered by this Review.

4.6.4. **Behaviour Management**: One theme that surfaces time and again across a number of the agencies was that intervention was frequently intended to manage the behaviour of the young people, or to help their families manage that behaviour. This approach was the prevalent response with young people being viewed as problematic and referred to in terms of "*hard to reach" "rebellious" "challenging behaviour*" rather than by attempting to understand the behaviour and provide sustained support.[47] In understanding why this might have been the case, it should be recognised that there is a significant body of evidence regarding wider societal attitudes to young people which are often punitive and critical.

4.6.5. A frequent feature of the 'behaviour management' approach was to simply tell the young people that they must stop behaving in certain

[47] OFSTED (2011:18)

ways. This can be seen across the agencies from CIT, to YOT workers to children's Social Workers. Frequently the young people were told that certain behaviour was '*risky*' which was both self-evident and yet meaningless in the context of the dynamics of Child Sexual Exploitation. It is of interest that even CIT who were believed to have expertise in CSE are recorded as having spoken to the young people in these terms. Such a didactic approach is generally likely to be ineffective, not least with teenagers who are particularly resistant to simply accepting adult instruction and by the nature of their developmental stage are more likely to challenge or reject adult views on what is acceptable behaviour. For these 6 young people who had also experienced adults as often dangerous and untrustworthy, the likelihood of responding to adult instructions simply to behave differently was even less likely.

4.6.6. On occasion this instructional approach also had a threatening or punitive feel to it that also is unlikely to have been constructive. In January 2009 [redacted] was "*spoken to about the need to protect herself and the baby and was told how seriously a new/further referral to CSC would be treated*". Social Workers will sometimes need to explain to parents what the potential implications may be if there are new concerns about a child, but this needs to be managed in a sensitive way. We know from [redacted] discussions with other workers that she experienced this as threatening and disempowering and it simply had the effect of making her anxious about CSC involvement and closed down communication.

4.6.7. Time and again this behaviour change was intended to be achieved by referring the young people and their families to the Family Support teams, and these referrals were made both by Duty and Assessment Social Workers and by other agencies. This is reflective of the research available in relation to interventions with adolescents, which identifies that typically the focus of work with adolescents has been on their *" behavioural and emotional problems rather than on abuse and neglect*" [48]. Little evidence has been provided of conscious, clearly articulated and recorded decision making as to whether the young people might meet the Significant Harm threshold.

4.6.8. **Referral for Family Support:** The absence of intervention by Children's Social Care at a number of crucial points in the young people's lives is apparent within this Review. When CSC did intervene it predominantly did so by referring the young people on for another team to manage the behaviour. Most often that would be the Child and Family Support Team, on other occasions the Young People's Support Team, the Intensive Support Team or the Child and Adolescent Mental Health Team.

4.6.9. In the absence of good quality assessments of the Young People, there was also at times a confusion of purpose in relation to the

[48] Rees et al (2011)

referrals for intervention. For example the making of a referral to a parenting programme for [redacted] in 2010 is of questionable value when it was apparent from the evidence at the time that the main risks to her parenting of her child were her alcohol use and her emotional distress. Similarly unclear was a decision by a social worker to refer [redacted] to CAMHS and to Positive Activities for Young People in order to "*help [redacted] understand her behaviour and gain control over her actions."* There was no evidence that the agency itself had any real understanding of [redacted]'s behaviour, as evidenced by the apparent conviction that simply referring her to these agencies would enable to control what was happening to her. This routinised approach to referring on to other services continued time after time with no assessment of whether it was proving effective.

4.6.10. The reasons for this are likely to be several, including pressures of work, agency culture, poor supervision, lack of confidence or skills in working with this age group, and possibly most significantly a lack of available services relevant to this age group. What has also been identified is that from 2010 onwards the focus at the most senior level of Children's Services was on managing less children in care and, in particular, encouraging '*family based support'* for teenagers. Social workers were therefore being given a clear message from senior management about the approach to intervention with this age group.

4.6.11. The IMR for Children's Social Care has in particular highlighted the impact on decision making for these young people of the "*Supporting Children and Young People to Remain within their Family'* policy, informally referred to as the '*non-accommodation policy'* This policy was in place between September 2006 and October 2012, when it was rescinded. The policy had clearly caused serious misgivings amongst practitioners and other agencies for some time. The policy lays out a very strong argument for keeping children, and especially young people with their families, with little balance in relation to identifying the risks for some of these young people. It includes a very prescriptive procedure for any applications for a child to be accommodated and the statement: that: "*apart from situations where children and young people are very vulnerable and cannot live with their families, the Authority WILL NOT LOOK AFTER(sic) children/young people on a long term basis."* The CSC IMR concludes that this policy "*seemed to significantly limit the safeguarding options of social workers and their managers in the Duty and Assessment Team to remove young people from harmful situations".* It is important to note that this policy reflected national government priorities at the time. Whilst the general concern about this policy's impact on accommodating children is a legitimate one, no specific evidence has been provided that this was a direct factor with individual young people subject to this review.

4.6.12. Duty and Assessment social workers were responding to referrals about these 6 young people almost entirely at Level 2/3, ie below the threshold at which Child Protection Proceedings would have been considered. It is therefore difficult to make a causal link with the '*non-*

accommodation policy' and the response to these young people. [redacted] and her child were accommodated with foster carers under S20 of the Children Act, the intention being for this to continue for two years. The focus of this decision however was the safeguarding of [redacted] child. When the placement broke down further Child Protection planning related only to [redacted], not to [redacted] herself, who was viewed as having discharged herself from care and no further option of accommodating her appears to have been considered.

4.6.13. The only young people who were considered to be at risk of Significant Harm and therefore subject to Child Protection Plans were [redacted] There is no evidence that S20 or Care proceedings were ever considered for [redacted] and therefore, again, the issue of long term accommodation would not have arisen. There is one reference in 2009 to a residential placement being found for [redacted] but there is no evidence that this was ever pursued and the degree to which the '*non-accommodation policy'* prevented her being accommodated is difficult to assess. If anything the fact that this was not pursued is consistent with the general pattern of poor planning and drift that featured throughout [redacted]'s Child Protection plan. Nevertheless, although making a direct causal link with the *'non-accommodation policy'* is problematic, it clearly had a significant impact on the general approach to interventions with young people and even if it was not a conscious reaction must have influenced the mindset of Social Workers regarding thresholds for intervention.

4.6.14. The actual content of the work that was to be undertaken by the Family Support teams remains largely undefined. There is no evidence as to whether the intervention was: based on a particular model; underpinned by any particular knowledge base; targeted at the particular needs of young people or had an identifiable practice framework. Records of the work undertaken by Child and Family Support Workers show little evidence of a plan of work being reviewed over time. In the absence of such a plan it appears to rely significantly on the individual skills, creativity and common sense of the Family Support Workers, some of whom clearly worked hard to engage with and help the families, others who struggled with the task.

4.6.15. These interventions via Family Support whilst providing some short term help were largely ineffective in establishing support and the safeguarding of the young people in the long term. One of the explanations for this continuing pattern is the absence of any identifiable management overview of the effectiveness of interventions other than on a very short term basis. General practice nationally for family support teams which was apparent here, was for them to offer a short term, task centred service focussed on helping parents to improve their parenting skills and helping the young people to change their behaviour. However, what was absent was any evidence that managers either at team, middle or senior level, reflected on whether this approach was effective. Research as to where this approach was successful has identified the key components that were required for positive outcomes including:

- Systematic assessment of family functioning
- Problems identified, goals set, work planned, clear agreements drawn up
- Work with parents; emphasis on appropriate parenting including behaviour management through positive reinforcement, boundary setting, developing routines
- Work with young people, exploring views, identifying triggers to conflict and behaviours that are dangerous, being alert to any evidence of abuse
- Using sessional staff to befriend young people, build self-esteem and engage them in positive local activities.

4.6.16. Conversely the research identified that the outcomes were poorer when:

- parents and young people could not be engaged or showed no motivation to change
- the young people remained in involvement with 'antisocial peer groups'
- young people's mental health difficulties or parental conflict was chronic or severe
- Short term interventions were the main response to chronic or severe difficulties.[49]

4.6.17. Whilst some of the positive components did feature there is no evidence that they were part of a comprehensive and systematic approach. There is significant evidence that the components likely to lead to poorer outcomes were however in place. There is further no evidence that at any point during these young people's journey through the system, that any consideration was given as to the effectiveness of repeated referral to the Child and Family Support team or Young Person's Support team.

4.6.18. If we ask why individual responses were ineffective, one of the reasons we must consider is the apparent absence of any culture of reflection or review by operational managers in relation to young people's experience of these services and their effectiveness. This in turn leads to a similar question regarding the focus of Senior Management. The lack of any clear framework or culture focussing on practice effectiveness is apparent not simply in relation to the specialist needs of these young people, but across wider service provision and child protection practice. Until 2010 there was no framework in place requiring a specific planning process for those identified as being a 'Child in Need'. No evidence has been provided that there was a performance framework in place which focussed on the effectiveness of interventions and there was no meaningful

[49] Rees et al (2011;103)

contact between senior management and frontline staff. Given the particular difficulties of working with such adolescents there is a heightened requirement for an evaluative culture to be built in.[50] Without such a culture it becomes more apparent why at the front line the practice appeared to be simply to provide 'more of the same' irrespective of its long term impact.

4.6.19. **Co-ordination of planning.** The effectiveness of individual agencies' interventions in relation to long term outcomes for the young people is not easy to assess because of the chronic nature and complexity of the young people's problems. What was required was well co-ordinated and intensive support across a range of services but this was noticeably lacking. Given the number of agencies involved at any one time, the route for co-ordination would have been either through a CAF, through a clearly managed Child in Need Plan or Child Protection procedures.

4.6.20. It is evident that the level of need and the risk of significant harm in relation to these young people would have effectively precluded the use of a CAF in most circumstances. There is reference to use of a CAF on a small number of occasions, but due to a lack of recording, there is no evidence of a clear sense of purpose or proper review. From the information available, the CAF initiated in relation to [redacted] presents as being confused, both in terms of the process and the content. Agencies recorded different understandings as to why the CAF was initiated, whether it related to [redacted] or her child and who was the lead practitioner. The CAF meeting then recommended an Initial Assessment suggesting either confusion about its role, or more likely, that agencies were trying to use the CAF process to reinforce previous attempts to make child protection referrals to CSC. The Initial Assessment resulted in a referral for Family Support, with the CAF appearing to continue alongside but without any clear link between the two processes.

4.6.21. This episode highlights the difficulties the agencies clearly had in establishing a clear co-ordinated approach to managing interventions. Why the CAF process was so limited is likely in part to have been because it had not been effectively rolled out or embedded into routine practice. This has been confirmed in the unannounced OFSTED inspection of December 2009, which referred to the CAF being under-utilised by agencies.

4.6.22. Similar problems can be identified across the health provision. A range of services were involved with each individual young person and yet there was no overall co-ordination of the healthcare provision. Whilst individual health professionals communicated with each other there was no evidence that staff ever met together as a team to consider what needed to be done, who should do it or how the various interventions could be best co-ordinated.

[50] Rees (2011:97)

4.6.23. It is also evident that it was not only the professionals but more importantly the young people who found this lack of co-ordination difficult to deal with. [redacted] in particular spoke to Early Break at around this time, and described feeling overwhelmed by all the agencies involved. The Early Break worker spoke to Action for Children to try to see if the numbers of appointments for [redacted] could be reduced as they clearly felt this was having a negative impact on [redacted]. However, in the absence of any clear process this does not appear to have been taken any further. The Early Break worker spoke of a culture of services "*dipping in and out of* [redacted]*s life",* a perception which is supported by the information available to this Review. [redacted] also spoke of feeling overwhelmed by professionals, leading her to avoid meetings '*She wanted people to go away and stop 'stressing her out'"*

4.6.24. What is apparent from this inability to co-ordinate at a multi-agency level is a sense of helplessness by agencies leading to individualised working interspersed with often unsuccessful attempts to make child protection referrals to Children's Social Care.

4.6.25. Similar problems with a lack of planning and co-ordination are visible at points when the young people were viewed as meeting the threshold of 'Child in Need'. What is noticeable is that there is rarely, if ever, a consciously articulated identification that any of the young people should be considered a Child in Need or that there should be any planning process as a result. As previously noted, the young people were on a number of occasions referred for Family Support, but there is nothing to suggest that this was seen as part of an overall plan to meet their needs. Rather it appeared as a stand-alone response with both the Family Support workers and other agencies attempting to link together at times, but without any overall sense of co-ordination. When there were attempts at co-ordination by Children's Social Care, these were generally reactive responses by individual practitioners, not part of a planned and structured response or with any formal involvement of qualified Social Workers.

4.6.26. In 2007 the Safeguarding Board had launched its 'Threshold Model for Safeguarding and Promoting the Welfare of Children' which outlined how services should work together to meet children's needs. The policy referred to the need for a designated lead professional in '*complex cases'*. However the policy did not establish how this professional would be identified or provide any help and guidance in putting a meaningful multi-agency system in place. Neither was there any requirement to develop Child in Need Plans. That individual practitioners working across a very wide range of agencies would be able to set up and co-ordinate such a system on a case by case basis was unrealistic and provides considerable insight into why practitioners frequently failed to work in a co-ordinated fashion across agencies.

4.6.27. The lack of any expectation to work to a clear plan for a Child in Need also impacted on provision at the end of other formal interventions. When [redacted] left the foster care provided for her and her child she was

deemed to have voluntarily discharged herself from Care. She was allocated a support worker from the Young Person's Support team, whose main focus appeared to be arranging accommodation. However, [redacted] had been accommodated as a result of being "*at risk of sexual exploitation and unable to put* [redacted] *needs before her own".* Her child's needs were responded to through the child protection processes, however, there is no evidence that risk of further sexual exploitation was considered or any plan put in place to [redacted] needs.

4.6.28. The lack of any 'step down' planning is also apparent when [redacted] was removed from the Child Protection Plan. [redacted] was removed from the plan because it was concluded that there was a lack of evidence that she met the threshold of being at risk of significant harm. Her wider welfare needs and vulnerabilities did not lead to recognition that she remained a Child in Need and no planning took place to help manage the transition. It appears that two of the factors which contributed to this response to [redacted] were her age, in that she had recently become 17, and her difficult sometimes aggressive behaviour towards professionals as noted in some meetings.

4.6.29. A related and significant feature of the young people's experience of agencies was the impact of a constant turnover in allocated practitioners within some agencies. This is most dramatically evidenced in the turnover of social workers involved with [redacted] During 2010 [redacted] had 4 different allocated Social Workers as well as contact with at least two duty workers. Over the course of her involvement with CSC she had contact with at least 13 Social Workers and Family Support Workers and 4 managers had responsibility for overseeing the work with her. The Child Protection Conference Chair in October 2010, specifically acknowledged to the family that this was unacceptable.

4.6.30. Children's Social Care was not alone in this turnover of staff. Education Welfare acknowledged that, in part due to cuts in its budget it struggled to ensure a consistent approach. The YOT IMR has also recognised that it suffered from a similar problem. What is of concern however is that this issue was identified for the YOT in a previous Serious Case Review (Child A) in 2010. There is no evidence that the recommendation from that Review which was to: '*examine if a single allocated case manager would be more beneficial from the young person's perspective*", has been acted upon and the IMR for this Review has made a recommendation, not to change the practice but again to: "*Review effectiveness of multiple workers working with young people"***.** This suggests a passivity of approach to learning from Reviews and the author would therefore suggest that the Safeguarding Board is particularly scrupulous in holding this agency to account as a result of this Review.

4.6.31. The nature of service provision and the range of needs that the young people presented with meant that there would always need to be a significant number of professionals and agencies involved with them.

However, there is no evidence that any of the responsible managers considered how best to manage this, how changes of practitioner could be minimised or what would be the impact on the young people or the quality of assessment and intervention as a result. There are a number of probable explanations for the high turnover of allocated workers, including: staff shortages; high usage of agency and interim staff; organisational redesign to deal with staff shortages or other policy changes; specialisation of job roles.

4.6.32. **Child Protection Planning**: When the young people did become subject to Child Protection processes, these were of a poor quality marked by drift, poor adherence to procedures intended to act as checks and balances, a lack of planning or review and poor recording.

4.6.33. During the time period identified for this Review, [redacted] were identified by Rochdale as having crossed the threshold from Child in Need to Child at Risk of suffering significant harm and therefore subject to Child Protection Plans in their own right. [redacted] was very briefly a Looked After Child having been voluntarily accommodated in foster care in response to concerns about her own child. [redacted]'s children were subject to Child Protection proceedings, but she was not, despite consistently extremely worrying behaviour including aggression, self-harm and other indicators of serious emotional distress. [redacted]'s child was subject to Child Protection Planning but she was not.

4.6.34. [redacted] both became subject to a Child Protection Plan in [redacted], having been involved with a range of services, including Family Support, and been subject to a previous plan in [redacted] when they moved to the area from AreaD. Information from that time and the intervening years suggests that there were significant problems within the family throughout their childhoods and a number of referrals had been made previously. The view of the IMR author for Children's Social Care was that the Child Protection plans in [redacted] were ended prematurely and that there was a case at that time for removal of both girls as a consequence of "*neglectful parenting, lack of supervision, and minimisation of the risks of potential sexual abuse from extended family members*." What becomes apparent is that the young people's needs had been badly met for some considerable time prior to them being subject to child sexual exploitation and that neglect in different forms was a feature of much of their lives.

4.6.35. The ultimate trigger for initiating Child Protection procedures was referral by the Police and CIT in August and September 2008 specifically identifying that the two young people were amongst a group of girls being sexually exploited. [redacted] was also involved in this investigation but was not made subject to Child Protection procedures. The rationale in the Initial Assessment for [redacted] being that although the concerns about sexual exploitation were substantiated she was not considered to be at risk of ongoing harm as her parents were believed to be protective and in any event did not want involvement with Children's Social Care. This illustrates a recurring

theme in the assessments of the young people, in that all too often parental reassurances were accepted and little effort was made to understand the risks from the young person's point of view. Again [redacted] was assessed as being 'out of parental control' rather than being vulnerable to further abuse.

4.6.36. However, it is also important to note that [redacted] parents have a very different perspective in that they told this Review that they made numerous phone calls to Children's Social Care and "begged" the department to take [redacted] into care in order to protect her.

4.6.37. It is clear that along with the central issue of Child Sexual Exploitation there was significant historical information that should have informed the Child Protection Plans for [redacted] However, the Core Assessment was not completed until 5 months after the Initial Child Protection Conference took place and as such there was no comprehensive assessment on which to base the Plan. This appears to have set the scene for the following year that [redacted] was subject to a CP plan and the four and a half years during which [redacted] was subject to a Plan. The Plans did not refer to Child Sexual Exploitation or include the criminal investigation as a core element, they had no clear outcomes or detailed actions as to how the young people could be protected and supported and all the actions identified were the responsibility of their mother who had shown she was unable to keep her children safe.

4.6.38. Whilst the key role for assessment sat with the Social Worker, what is also apparent in the following months and years is the ineffectiveness of the multi-agency group whose role it was to manage and oversee the plan. Child Protection Conferences did not review the plans against the actions, core group meetings were not always well attended, there was poor recording of meetings and an absence of police involvement in the core group. There was frequently no obvious outcome from meetings which often appeared to be a predominantly a discussion of what had happened without any evidence of active review and planning. A sense of helplessness is described by the IMR Author about the discussions held within Strategy and other meetings. The impression given through these records was that 'nothing could be done'.

4.6.39. The rationale for decisions was often unclear and intervention lacked direction. There was reference for example to a possible foster placement or therapeutic community for [redacted], about which [redacted] herself was positive, however there is minimal further reference to this in the records and eventually it is just noted as no longer being necessary. [redacted] care proceedings were initiated, but it is difficult to detect what in particular triggered this action or what was felt to be fundamentally different about the risk she faced. There is no clear explanation for these decisions; rather it appears that it is simply a response to the passage of time.

4.6.40. What also emerges is a pattern of referring to Legal Gateway meetings as if these would provide an answer to the difficulties rather

than recognising their role as being the provision of legal advice to the social work practitioners and managers. SW4 is noted on a number of occasions as referring at Child Protection conferences to the need for a Legal planning or Gateway meeting to plan "*a way forward*". On one occasion she stated that [redacted] was "*crying out for some sort of support and containment"*. This comment in particular suggests that it was not something the social worker, her manager, or possibly even the Child Protection planning process believed they were able to address.

4.6.41. One of the most powerful examples of the collective inability to effectively assess and manage the risks facing [redacted] was the multi-agency response to information known about AdultD. From 2008 onwards the agencies were provided with a series of concerns about this man and the risk he posed to young people, yet decision making was inconsistent and unclear and there is little evidence of any structured assessment of the risk he might pose to these or other young people. That the young people concerned were already known to have been sexually abused and exploited and were to some degree estranged from their own families should have identified them as particularly vulnerable to being further abused.

4.6.42. A summary of what is known and what action was taken is as follows:

April 2008	[redacted] told school she had had drink spiked whilst at AdultD's
August 2008	[redacted] known to be living with AdultD's
Oct 2008	[redacted] told school she had sex with AdultD's son. AdultD's family said to be well known to CSC. [redacted] living with AdultD
Oct 2008	Police report identifies AdultD known to pose a potential risk of sexual abuse
Oct 2008	[redacted] refuses bail if she is not allowed to live with AdultD
Nov 2008	SW notes 'concerns' about young people visiting AdultD
Nov 2008	SW states may give agreement to [redacted] staying with him if he sorts out the bedroom and reminds him of responsibility to keep [redacted] safe
Jan 2009	Core Group. Recorded that [redacted] at AdultD, no reference to a decision as to whether this has been agreed by SW/Core group
Jan 2009	CITC and Police inform SW of [redacted] No reference to any decision/advice by CSC as to contact between AdultD and children.
Feb 2009	CP Review informed AdultD is being investigated. No reference to any safeguarding action re risk he may pose to children
March 2009	[redacted] informed CSC that AdultD had been arrested for "*running a prostitution ring from home*". . No direct evidence of information sharing between the Police and CSC. YOT stated AdultD on 13.03.09, questioned about sexual activities with a minor and bailed until 11th April 2009
March	[redacted] arrested for enticing girls, including [redacted] into prostitution. Bailed to

2009	AdultD's home. condition of no contact with [redacted]
July 2009	[redacted] known to be living with AdultD
August 2009	Child Protection Review Conference. Concerns about AdultD again recorded. It was said that previous allegations against him had not progressed due to lack of evidence but the police continued to gather evidence about him
August 2009	[redacted] staying at AdultD's and unresolved confusion as to whether it was allowed. CIT records refer to an "Emergency Strategy Meeting" and a '*procurer order in place in relation to the property'*
August 2009	Dissension Panel: Stated AdultD was not blood relative, He had been issued with a Final warning under Section 2 of the Child Abduction Act in respect of harbouring a child under 16. The Panel considered there were risks relating to him that were not being adequately addressed.
August 2009	[redacted] asked SW to help her find independent accommodation as she no longer wanted to stay at AdultD's. SW was concerned that [redacted] was too vulnerable to consider an independent tenancy and there were concerns about AdultD, but she could remain there temporarily until appropriate alternative available.
June 2010	[redacted] Core Group meeting. Still said to be visiting AdultD, but he had been "checked out by police"
July 2010	[redacted] and school asked SW what advice was re AdultD. SW said this would be discussed at Core Group meeting
July 2010	[redacted] Core Group Meeting. No record of advice/discussion.
Oct2010	AdultD arrested, daughter taken into care
15 October 2010	Mother [redacted] told not to allow [redacted] to have contact with AdultD
Novemb er 2010	Core group. SW says there can be no contact with under 16s due to bail conditions.
January 2011	CP Review: SW says there can be no contact with under 16s due to bail conditions
April 2011	Information received that [redacted] seeing AdultD's sons with her mother's agreement. No action taken.

4.6.43. What this chronology illustrates is:

- an absence of any formal risk assessment process on which decisions could be based;
- a pattern of delaying decision making, for example adjourning decisions to the Core Group;
- discussions either not taking place at Core Group or a decision not being taken;
- contradictory decisions being made regarding the risk to [redacted] of living at the address.

- absence of liaison between the police and children's services about the risks that AdultD might present and no evident attempt to collate information about what was known about him to inform safeguarding decisions, as opposed to charging or bailing decisions.

4.6.44. It is not always easy to identify what information was available to members of the Core Group as a whole, for example whether they knew that family members had been told by the Social Worker in July 2010 that the Core Group would make decisions about the appropriateness of contact. Clearly if such information was not properly shared by the Social Worker this would have undermined the group's effectiveness. In any event there is little evidence of a culture of reflection and challenge in the group.

4.6.45. Information was clearly available and known at the time that would have indicated that AdultD presented a significant risk to children. Comments have been made that AdultD and his family were "*well known*" to the police, Children's Social Care and within the local community. There is no curiosity about why the young people, particularly [redacted] who was not related to this man would prefer to live at this address rather than with their immediate family and what that might indicate about the quality of relationships with their parents. That the lack of curiosity may have reflected a lack of practitioner time and therefore capacity to respond should not be discounted.

4.6.46. The difficulties in finding suitable accommodation for this group of young people is evident on a number of occasions and identified in the Housing IMR. The young people were also often unwilling to accept alternatives offered to them as in their judgement these alternatives represented a worse option. It is possible that the difficulties agencies experienced in finding accommodation may have impacted consciously or unconsciously on their judgement about the motivation of AdultD. This combined with other weaknesses in the working relationship between the young people, their families and practitioners, not least the Social Worker may also have impacted on their ability to focus on the risks to the young people in this setting.

4.6.47. The Social Worker who was key to this process no longer works with the Authority having been subject to a disciplinary process which is yet to be completed. As such it has not been possible to obtain any direct information which could help to explain a standard of practice which appears so poor with hindsight. Contributory factors as identified elsewhere, such as high caseloads, lack of organisational prioritisation of adolescents and lack of knowledge regarding sexual exploitation may have played a part.

4.6.48. However, the gap in the quality of practice that could reasonably be expected of an experienced social worker remains stark. If this approach to practice was significantly the result of poor skills on behalf of an individual social worker, it leaves unanswered the question as to why management oversight had failed to recognise the quality of practice, to challenge the thinking or to intervene. There is

no evidence that the social worker sought help and advice or that active supervision was provided to her in relation to this case. During the time period this took place the Social Worker herself had become a team manager. There is no evidence available to this Review as to what supervision, if any she received in this role.

4.6.49. What is also of concern during this period is the quality of liaison between CSC and the Police, which is very variable. Whilst there is evidently some contact between the two services, it is inconsistent and there is little evidence that whatever information exchange there was regarding the risk presented by AdultD resulted in any effective protection for these or potentially other young people.

4.6.50. The Police IMR notes that there were 40 Child Protection Conferences for [redacted] but provides no record of their attendance or other involvement. The exception to this lack of records is one occasion when the Police representative dissented from the decision to remove [redacted] from the child protection plan. The IMR suggests that problems with the migration of data when IT systems were updated may account for the significant gap in the records for this time.

4.6.51. If this is the case, this loss of information represents a serious weakness for the Police and has been identified in at least one previous Serious Case Review. Information from other agencies does evidence that there was some attendance at Child Protection conferences and Core Groups by the police, but also records that concerns were also raised in late 2009 due to the lack of Police attendance. Given the gaps in information the reasons for the Police absences remain unexplained. As a result the Review has been left with an incomplete and unsatisfactory picture of the involvement of the Police in the routine Child Protection processes.

4.6.52. **Safeguarding the young people's children**. A marked recurring theme in the young people's experience is the shift in agency response when they become parents. An identifiable pattern which has emerged in this Review, a pattern which has also been specifically commented on by [redacted], is the difference in approach adopted to the young people's children in contrast to that adopted for the young people themselves.

4.6.53. One of a number of examples of this was in 2008 when Action for Children made a referral to Children's Social Care in which a range of concerns were identified both about [redacted] care of her child, but also regarding indicators that [redacted] was experiencing sexual exploitation. This was shortly afterwards followed by a referral from CIT also identifying sexual exploitation. The focus of the Initial Assessment was on [redacted]s Child who was then made subject to a Child Protection Plan under the category of neglect. In the absence of any plan to respond to the safeguarding needs of [redacted] The Chair of the Child Protection Conference specifically recommended that [redacted] also be allocated a social worker. However although the case was allocated, no strategy meeting ever took place and [redacted]'s safeguarding

needs were not assessed. The focus remained on her child or on her parenting.

4.6.54. Another conspicuous example of this focus on safeguarding the baby rather than the adolescent mother was [redacted] when [redacted] took an overdose. An Initial Assessment for [redacted] concluded that although she was in a "fragile emotional state" she was not currently at risk. However a Core Assessment was undertaken with regard to [redacted]'s child because of his mother's fragile emotional state. Although she was nearly 18 at this point, [redacted] was still herself a child.

4.6.55. Whilst it was clearly right that agencies assessed and responded to the needs of the young people's children, the contrast with the way they were themselves assessed and responded to is noticeable. Other agencies also recognised that they tended towards a similar approach at times in more easily recognising the babies' needs. Action for Children for example also acknowledged that the focus of both their referrals regarding [redacted] and [redacted] was primarily on safeguarding the children rather than the young people.

4.6.56. As has already been noted there is explicit evidence that the organisational priority within CSC was on young children not on adolescents and this evidently had a significant impact on the quality of the intervention with the young people. However, the Pennine Acute IMR also articulated another explanation of this pattern which adds to our understanding: "*there was an underlying sense that something tangible can be done to protect the babies whereas the solutions and options available to protect the young people in what was becoming a deeply entrenched pattern of exploitation and abuse was far more challenging and uncertain*."

4.6.57. What we know from research is that these concerns represent commonly experienced problems and failings in providing services to this age group. Evidence from research identifies a reluctance to intervene with young people[51] for reasons that mirror what was at times taking place with these young people. The response to the young people's babies throws into stark relief the difficulty experienced by many agencies not only in how they related to and understood the young people, but also their confidence and ability when it came to intervening with young people. Working with young people who have been sexually exploited requires particular strengths and skills in workers which requires support and development in training and by their agencies.

4.6.58. There is a strong body of research to identify that the sort of weaknesses seen here in the provision of services to this group of young people represents a common pattern. The 2012 Government review of Child Protection concluded there was: *"a worrying picture*

[51] OFSTED 2011
Turney et al 2011

with regard to the protection and support of this group. This is characterised by a lack of services for adolescents, a failure to look beyond behavioural problems, a lack of recognition of the signs of neglect and abuse in teenagers, and a lack of understanding about the long-term impact on them "[52].

4.6.59. Adequate age appropriate services, specialist help and assessment tools are often lacking given the focus on younger children and early support for families with young children. At a national policy level this age group is largely the subject of concern in relation to their perceived impact on others, such as offending and anti-social behaviour, rather than in relation to their own welfare needs, as such reflecting wider societal attitudes. This then is mirrored in the provision of services and policies at a local level.

4.6.60. At the level of direct practice, the lack of expertise, ability and at times empathy in working with young people has been evident in several of the agencies and with some individual practitioners. Maintaining a sustained relationship over time with young people who have had very damaging experiences is genuinely difficult. The way in which the young people's distress is demonstrated combined with a common pattern of testing of the relationship with workers by rejection can lead the worker to "*feel as depressed, as chaotic and as confused as they (the young people) do."*[53] It is crucial, that as [redacted] stated, any focus on the young people's vulnerabilities does not become a diversion from the responsibility of their abusers. However, services and individual practitioners will serve those young people better if their skills and understanding of this age group are improved and simplistic beliefs about the needs of young people are challenged.

4.6.61. A further insight into why the intervention with these young people was so limited has been identified by a number of the agencies. The Child Protection System has been developed primarily to focus on abuse within the home, rather than by non-family members. This was reflected most explicitly in the organisational approach of the police at that time. The investigation into offences against children could either have been undertaken by CID officers who had no background in safeguarding, or by the Police Public Protection Investigation Unit, which had a much clearer understanding of children's needs and safeguarding. The key factor that determined which of these would undertake the case was whether the offender had '*care, custody and control'* in relation to the victim – that is whether it was or was not taking place within the family.

4.6.62. Whilst this distinction between inter-familial and extra-familial abuse has now been recognised as unhelpful by all the agencies, careful consideration is nevertheless required as to how best to mobilise services to support young people experiencing sexual exploitation.

[52] HM Government 2012
[53] Pearce (2009: 151)

There are aspects of the Child Protection process which do not lend themselves well to engaging with young people and this Review would urge consideration of whether other routes than Child Protection planning may need to be considered in the future.

4.6.63. What is also of note is that no information has been provided to this Review which demonstrates that agencies working with these young people looked outwards to learn from the experience of others as to how to approach Sexual Exploitation. As has been noted a number of authorities locally had gained considerable knowledge, but there is nothing to suggest that any of these were approached for help or advice. It is not possible to know why this did not take place, although the lack of good critical supervision, the lack of recognition that each case was part of a wider picture and resource pressures may well have contributed to what appears to have been a fairly insular approach to the problem at the time.

4.6.64. Similarly, despite the involvement of a project run by Barnardo's who have been leaders in recent years in developing our knowledge and understanding of CSE, the connection was not made either by staff in the project, or by other agencies that this organisation could offer expertise. Barnardo's has recognised that because the project was focussed on meeting adult needs their staff did not have expertise in this area. It has therefore been decided not to provide such projects again in the future. However it is perhaps a lesson to national voluntary organisations to ensure that their national policy imperatives are well integrated with locally provided services.

4.6.65. **Challenge and escalation.** In common with other serious case Reviews, what is also evident here on too many occasions is a lack of critical but constructive challenge within agencies and across agencies. This can be seen both on an individual basis but also in the work of the Safeguarding Children Unit[54] which had a role in ensuring checks and balances were in place, but clearly struggled to fulfil this role effectively at times.

4.6.66. It is important to note that there were challenges made, some of which were successful. For example in 2008 when the CSC Social Worker expressed a firm view at the initial Child Protection Conference that [redacted]'s needs could be met within a Child in Need Plan, other conference members disagreed with this assessment and she was as a result made subject to a Child Protection Plan.

4.6.67. On a number of occasions individual agencies or professionals felt unhappy with significant decisions that were taken in relation to the young people but seemed unable to translate these concerns into effective challenge. Sometimes these concerns were not communicated outside of the agency for example one of the YOT workers, PAYP2, commented that it was unclear in Core Group meetings how [redacted] was to be kept safe. There is no evidence

[54] This is now known as the Safeguarding Children Unit

however, that his concerns were raised in the meetings themselves. Whether this was a lack of confidence in relation to that individual worker, or a lack of understanding of participants role in the Core Group is not known. This worker attended meetings with the YOT Case Manager, who would have had a more senior role and might have been expected to raised these concerns, if he did not feel able to. Again, however, it suggests that there was an absence of managerial oversight either in reviewing the individual worker's contribution in the Core Group or in ensuring their concerns were taken up through management structures.

4.6.68. On other occasions practitioners expressed their concern but either could not or did not follow up those concerns when they were dissatisfied with the outcome. Examples include:

- October 2008, referral made by CIT to CSC regarding [redacted]. No action taken by CSC as they had recently undertaken an initial assessment. No follow up by CIT
- 2009 both the School Head and the school health practitioner expressed their unhappiness about CSC decision to end their involvement with [redacted] But there is no evidence that this led to other action
- 2008 a Child and Family Support Worker challenged [redacted]'s Social Worker after he refused her request to make a referral to mental health services. However, he would not accept her view that such a referral was necessary. The CFSW did not take this further.

4.6.69. A particular example is the challenge by the Core Group of the recommendation by Children's Social Care to remove [redacted] from her Child Protection Plan. A number of the agencies present would not agree to this recommendation as a result of which the decision was referred to the Dissension Panel, a meeting of senior managers whose role was to reach a decision in these circumstances. This panel confirmed that [redacted] should remain on the Plan and identified a significant range of concerns about the effectiveness of the work undertaken to date and the ongoing risks to [redacted]. Having received a clear message from the Dissension Panel what is then surprising is that when just 3 months later [redacted] was removed from the plan, the agencies who had previously objected to this course of action did not do so again. There is no information that any new course of action was considered in relation to [redacted] in the light of the Panel's comments. In a Child Protection meeting two months later there is nothing in the records to confirm that [redacted] was discussed.

4.6.70. Two possibilities suggest themselves as an explanation. Firstly that those who had dissented felt that the Panel process had in reality achieved little and the impetus to challenge further was lost. Alternatively, given that a particular note was made of [redacted]'s abusive behaviour in the group and that she presented as confrontational with professionals it may be that a sense of professional helplessness as

to how to intervene took over. There is no evidence that the Dissension panel had any further involvement in [redacted] case and no other evidence of management oversight. Given the comparatively unusual fact of a dispute between professionals in a Child Protection Conference, some form of review of the longer term outcome for [redacted] at a more senior level should have been considered.

4.6.71. That individuals such as these did challenge decisions which they felt were not in the young people's interest is of course positive. However what they clearly did not either feel able to do or believe they should do was take their concerns to their manager or through agency or Board escalation procedures. In the case of the Child and Family Support Worker's challenge the response of the Social Worker as it is recorded was very clearly intended to close down any further challenge and specifically referred to the position of a Conference Chair to reinforce the position taken. It is possible that a CFSW in these circumstances would not feel able to question the Social Worker further.

4.6.72. A number of the individual agencies have made recommendations regarding escalation of concerns and this is also identified for further consideration by the Board in Section 5.

4.6.73. **The role of the Child Protection Unit Reviewing Service.** The function of the Unit was to provide Independent Reviewing Officers to chair Looked after Children Reviews and to Chair Child Protection Conferences and Reviews. The role is intended to act independently of Children's Social Care front line functions and provide a quality assurance function in relation to individual cases.

4.6.74. This unit has rightly come under scrutiny given the limited evidence of effective oversight or challenge from those chairing the conferences. There are a number of occasions when Conference Chairs and IROs raised criticisms or concerns about the progress of work with the young people but there is no evidence that these concerns were pursued effectively outside the meetings. These included:

- September 2008: Conference Chair states that there should be a strategy meeting and allocated social worker for [redacted]
- October 2010 re [redacted]: Concerns about the number of social workers involved and the failure to undertake statutory visits.
- Evidence in minutes of meetings that the IROs were frustrated at the lack of progress in safeguarding [redacted] in particular

4.6.75. However there were also a number of times when there is no record that the Chairs or IROs raised issues that would have been within their remit to comment on or to escalate to team managers including:

- Failure by the Social Worker to meet with the young people as part of the Initial Assessment
- Decision to discontinue the CP plan in relation to a younger sibling of [redacted] despite no Core Assessment having been completed.

- Poor quality of Child protection Plans, often incomplete and with no identified outcomes.
- Lack of exploration of the dynamics of the exploitation including that of older 'Asian' males and young white working class victims.

4.6.76. In April 2010 there was a specific recording by the Chair of a Strategy Meeting that: "*Enquires to be made as to why a team manager from CSC (Children's Social Care) has not attended today's meeting. If sexual exploitation in Rochdale is to be tackled, it needs the commitment of CSC….. the Assistant Director of CSC needs to be made aware of the situation and his support given"*. The frustration of the Chair is palpable, yet there is no evidence that this was followed up after the meeting.

4.6.77. The IROs/Chairs confirmed during the IMR process that they had referred a number of their concerns to their manager, but received little feedback as to the outcome. It has not been possible to ascertain what then happened as the manager concerned no longer works for the authority and could not be contacted. There is no evidence of any correspondence between the Head of Safeguarding, who had operational responsibility for the Unit and Senior managers in Social Care of the increasing concerns during 2008 and 2009. The Reviewing Officers believed that the Head of Safeguarding would share their concerns, but were unclear if this happened. Some of the IROs also described a lack of supervision. Nor is there any evidence of formal meetings between staff in the Safeguarding Unit about the level and form of child sexual exploitation.

4.6.78. In attempting to understand why the IROs/Chairs seemed to find it difficult to escalate or press their concerns to a conclusion, particularly given that they were clearly frustrated and concerned about the practice that they were seeing, it is also important to understand the organisational context in which they worked. When the role was initially established it was viewed predominantly as facilitative, ensuring that there was an independent element to the chairing of Reviews. The role of professional challenge was not so explicitly required as it is now. Particularly since a strengthening of the statutory requirements upon the role in 2008 and the introduction of guidance for IROs produced in 2010

4.6.79. Further undermining their independence and confidence to challenge practice was the management structure that existed within Children's Social Care at the time. Until 2011 this unit was managed by the same Senior Manager who also had overall responsibility for operational service delivery. Such a system is fundamentally flawed in that it builds in a conflict of interests. Should IROs wish to raise concerns or complaints, they would not be doing so to their own independent manager, but to the manager operationally responsible for the practice under scrutiny and also responsible for them as individual workers.

4.6.80. No formal process existed for escalating concerns until 2012, which also throws light on why concerns were not evidenced in any of the information available, and more importantly, why individual IROs may not have felt encouraged to raise their concerns. The conclusion of the IMR was that: "*the Reviewing Officers felt that they had neither the status or the management support necessary to challenge the poor quality of the work they were seeing".*

4.7 The operational response: The context- Race, Class, Gender and Culture

4.7.1. As has been identified in Section 2.3 all of the 6 young people faced particular pressures and challenges in their lives as a result of aspects of their family experience, their gender, class and economic disadvantage as well as personal attributes such as learning disabilities. What is to some degree missing from this Review, given the level of involvement of the young people, is their own perspective on their lives and how these factors may have influenced events.

4.7.2. **Learning Difficulties**: A feature that has been identified in relation to all of the young people, with the exception of [redacted], is some degree of learning difficulties and the way in which such difficulties were recognised and responded to by services. [redacted]s mother in particular commented that agencies had not understood the extent of her daughter's difficulties and this is reflected in much of the evidence provided to this review. That 5 of the 6 young people did have learning difficulties is particularly pertinent in the context of what is known about the way in which victims of sexual abuse, including sexual exploitation are targeted. Information about the experience of young people with Learning Difficulties is under-researched however, it has been identified that young people with Learning Disabilities are at particular risk of being identified for grooming and exploitation.[55]

4.7.3. There were references by a number of agencies to either learning '*disability*' or '*difficulties'* in relation to [redacted] What is of some concern is that there was frequently a lack of clarity not only about terminology, which is used in different ways by different agencies and individuals, but more importantly what it meant in relation to the young people's lives and their ability to work with agencies. The starting point for these young people should have been some form of diagnostic and more importantly functional assessment, as to the nature of their Learning Difficulties. The importance of assessment is both to enable a better understanding by services as to the needs of a young person, but is also the key to accessing specialist services.

[55] Shine a Light (2013:16); University of Bedfordshire (2011:49)

4.7.4. Each of the young people's needs and abilities were different, but what they had in common was that there was either a lack of understanding of those needs or no evidence that those needs were taken into account when providing services or other interventions. [redacted]'s experience highlights both these concerns. The first recording was by the midwifery service which recorded in [redacted].

[redacted]

4.7.5. Although [redacted]s learning difficulties were noted by some agencies, predominantly within health, there is little evidence that it impacted on the way in which those agencies intervened or assessed her capacity to '*protect herself*' or any impact on her capacity to consent to sexual activity. There is no evidence of a holistic assessment or a co-ordinated multi-agency approach to her safeguarding or welfare needs. [redacted] was almost entirely absent from school from the age of 14 and prior to that her attendance had been very poor. What this meant and how it impacted on her learning difficulties was noted but otherwise largely unknown and little considered. It would be expected that given her absence from school for such extended periods the Education Welfare Service might have had considerable contact with her. However, because neither their records nor the school records have been located there is no information regarding their role.

4.7.6. The issue only became significant to services in 2008 in relation to care proceedings regarding [redacted]'s child. In the psychological assessment for these proceedings she was described as having moderate-significant learning difficulties suggesting that she would "*have significant cognitive deficits that impact upon her everyday functioning. It is highly probable that such cognitive deficits would have been evident from an early age …….an initial assessment by an educational psychologist with a view to implementing the statementing process should have been requested by the headmaster of [[redacted]s] junior school. If there was no such assessment then sadly [redacted] has been failed by the educational system'*. The absence of the school records means that it has not been possible to address these criticisms.

4.7.7. Two months prior to the psychological assessment a Social Worker had assured another agency that [redacted] had no learning difficulty, which raises concerns both about that worker's own knowledge base and a lack of awareness of the limits to that knowledge. What is more concerning is that there is nothing within the information from Children's Social Care that shows whether the psychological assessment impacted on the way in which the agency planned its work with [redacted] at that time or in the future. Neither was there any

information to suggest that this was shared with the Housing Department who continued to record [redacted] as having a mild learning difficulty, or with other key agencies such as CIT or the Police who appeared to be equally unaware of the possibility of such a learning difficulty.

4.7.8. The existence or degree of significance of the learning difficulties for some of the young people was evidently either completely unrecognised or significantly underestimated by most of the agencies. Agencies including the Police, YOT, Barnardo's, CIT, recorded nothing to suggest that they had understood Learning Difficulties might be of significance for some of the young people. Whilst non-specialist practitioners cannot be expected to assess learning difficulties, the presentation, behaviour and level of understanding exhibited particularly by [redacted] and [redacted] might have been expected to lead to more reflection on possible underlying problems.

4.7.9. The IMRs have provided little in the way of explanation for this lack of knowledge and recognition. However, it is not improbable that the factors which have repeatedly been identified by this Review as contributing to the quality of assessment and intervention will also have been operating in relation to learning difficulties. Nevertheless this should act as a reminder again to agencies of the need for staff to be alert both to the indicators of learning difficulties and also to the need to consider how this should impact on their interventions.

4.7.10. Specifically with regard to child sexual exploitation the information from this review again underlines the additional vulnerability of young people with learning difficulties. [redacted] mother spoke about her daughter simply not understanding what was happening in relation to the perpetrators. Others have commented on the need to learn how to educate this group of children and young people in the dangers of sexual exploitation, in a way that they can absorb the information given and subsequently put that information into practice [56]. As the agencies within Rochdale continue to roll out education to schools and the public, this is a factor that will need taking into account.

4.7.11. **Views of the young people in the context of background and class**. When considering the young people's identity and how this may have affected the response from services, what has been apparent to this Review is that judgements were made, again both consciously and unconsciously, about the young people, given their background and class. A number of the IMR authors have recognised that these young people were disadvantaged from many perspectives, socially, educationally, economically and by the nature of their experiences within their families. This was also understood at the time by many practitioners and there is evidence of some good consistent work with the young people as a result. For example Connexions Personal Advisors attempted to work constructively encouraging ability and the possibility of positive future options.

[56] Shine a Light

4.7.12. However, the response of many of the agencies too often suggests that there were limited expectations of the young people, their families and what life was likely to hold for them. The reactions of agencies suggests a high level of tolerance towards damaging and worrying experiences, parenting and life chances, that in other settings in the community would simply be seen as unacceptable. One of the most powerful examples of this relates to the response to the young people when they attend A&E as summarised by the Pennine Acute IMR:

"the discharge from A/E in the early hours of the morning to an unknown destination is worthy of more reflection in terms of equality of service provision…….. consideration perhaps should be given to the exploration of whether the same response would have been afforded a young person from a different social background."

4.7.13. The Youth Service described the young people as living in areas of significant intergenerational disadvantage. The approach that agency adopts and which serves as a good model to all agencies working in disadvantaged communities, is that their service should *"aspire to the same standards and outcomes in all communities and (not) accept something different because it is claimed to be normalized within a particular community".*

4.7.14. As has been widely noted prior to this Review, there were references to the young people's lifestyle or to them making lifestyle choices. Such references have been identified within this Review and have been evidenced across a number of agencies. Undoubtedly there are occasions when this was openly dismissive or judgemental, but equally if not more frequently, the context suggests a lack of thought on behalf of the person making the statement; the use of unhelpful shorthand, or a sense of helplessness as to how the situation could be changed. It is crucial that agencies do not simply focus on 'stamping out' the self-evidently unacceptable and judgemental attitudes of a small number of practitioners, but focus rather on changing the much more widely held and deep rooted attitudes in agencies, which often reflect those of the society from which practitioners are drawn

4.7.15. The concept of 'lifestyle' is likely to have been used as shorthand for a range of behaviours – sexual activity, alcohol and drug use, friendships seen to be negative, early teenage pregnancy. Whilst it was often legitimate for professionals to be concerned about the impact of some of these behaviours both on the young people and on their children, by summarising them as *"lifestyle*" with its implications of free choice and the potential for moral judgement, they betrayed and reinforced the concept that the young people had the freedom to make meaningful choices about the way they could live their lives. Given their economic, social and family backgrounds and the corrosive effect on the self of sexual exploitation this was fundamentally misconceived. In the words of [redacted]'s father "*it's what they expected of our children"*

4.7.16. A repeating feature of the young people's presentation was a high level of racism particularly towards 'Asian' people and this was something the agencies clearly failed to make sense of or respond to in a way which created an opportunity for the young people to explain their feelings.

4.7.17. [redacted] in particular caused a number of concerns in school as a result of her openly racist attitude and language towards staff and students including what is described as "*signs of obsessive behaviour towards Asian Students".* The school clearly took action, including eventually arranging for her to be transferred to another school, but what is not clear is how they understood [redacted]'s responses and whether there was any attempt to engage her in discussion.

4.7.18. The contradiction between the overt racism and aggression they often displayed and the young people's assurances that the 'Asian' men were their friends should have triggered curiosity. That it did not could be a result of the repeating pattern of contributory factors identified throughout this Review which impacted on the quality of assessment and intervention. However, as identified in the example above it is likely also to have been affected by other factors. Racist language and behaviour was used within the young people's families and it may be that professionals accepted this as normal within those families, and possibly within their community's culture. As identified in the example above, there were frequent occasions when the young people were challenged about their racism, but what appeared to be lacking was either the skill or the confidence to challenge in a way which opened up discussion rather than closing it down.

4.7.19. All of the agencies taking part in this Review have concluded that the service they provided was unaffected by the race of the men who were exploiting the girls**.** None has identified any apparent evidence to the contrary and most offered evidence of relevant policies and practice to demonstrate that their services are provided on an equal basis**.** There has been no direct evidence of what has been defined by some commentators as 'political correctness' – in other words an over-sensitivity about race leading to a conscious unwillingness to recognise or respond to the abusive actions of the men concerned because they were 'Asian'**.**

4.7.20. A Review of this nature, particularly when conducted under the spotlight of intense political and media attention, is unlikely to provide a fertile opportunity for individual practitioners to publicly expose their views, including the limits on their understanding about race, in this setting. In particular opening up for public criticism what for most people are complex, often contradictory views about race and difference, knowing that they will be quickly judged by those whose own views are not subject to the same scrutiny is particularly difficult.

4.7.21. Whilst there is no suggestion being made here that agencies have been anything other than genuine in concluding their services were not affected by race, it is the view of the author that this is unlikely to represent the real complexity of working in health and social care in a

racially diverse society. Evidence from across society as a whole, and health and social care services in particular, consistently show that attitudes to race, religion and other differences within communities do affect the way services are provided.

4.7.22. To some extent the lack of explicit evidence about the way in which the men were viewed is likely to be a consequence of a lack of information about them. There was very little direct interaction with the men concerned other than by the police and staff from Action for Children and Barnardo's who provided supported housing to the young people. There is minimal recorded information about the men from other agencies and as such limited opportunity to reflect on what that information might tell us about attitudes, whether explicit or more hidden. But other information was known about them, including their age in relation to that of the young people.

4.7.23. What has however been very striking throughout this Review is the frequency with which the men are recorded as “Asian”. The use of this term suggests that it meant something to those conferring it, but what it meant has not been made explicit, although IMR authors were encouraged to discuss this with staff. Using racially descriptive terms with little awareness of why they are being used, or how they might be received, is commonplace. However, the regularity of this term recorded in agency documentation suggests that either consciously or otherwise it was intended to convey a particular meaning. What is of concern, is that it was either not considered important to understand what this was, or it was too difficult to understand.

4.7.24. What is absent is any evidence that practitioners attempted to understand why the fact that the men were ‘Asian’ might in fact have been relevant and legitimate for consideration. There is little evidence that practitioners asked questions as to why quite well established social and racial boundaries were being crossed so frequently. Questions could have been legitimately asked as to whether ‘friendships’ between middle aged ‘Asian’ men and predominantly socially disadvantaged and ‘challenging’ white teenagers required further examination. Questions as to why these two groups who would not typically have significant social contact, had become so closely linked. Asking such questions may have led to the recognition that the girls were being targeted and groomed by the men. The degree to which workers understood the communities they worked in may also have contributed to the failure to recognise the unusual patterns of interaction between these two groups.

4.7.25. However, the fact that agencies considered they were not influenced by the men’s race in itself raises questions for those agencies. Firstly it is unlikely even in the least prejudiced workforce that staff will never be influenced by issues of racial difference. In this particular context – the sexual abuse of young girls by men of a different ethnic background, in a community where there has at times been openly racist attitudes and confrontation between different groups, a

completely 'colour blind' approach even if it existed, is potentially dangerous.

4.7.26. In depth analysis of the psychology and motivation of the men, or the causes of sexual offending is not within the remit of this report, whose focus is the way that agencies responded to the young people. However, some consideration is helpful as far as it contributes to the understanding and practice of staff within Rochdale, and beyond. That these young people were exploited by a group of men predominantly, but not exclusively from a South East Asian background, cannot be discounted and points towards the need for further analysis and research as to what significance this did or did not hold. However, a simplistic view that the mere fact of being 'Asian' is in itself explanatory of their behaviour, is dangerous not only because it is unjust and offensive to the wider community who share a South East Asian heritage. It is also dangerous because such simplistic presumptions represent a meaningless over generalisation, that is positively unhelpful if we wish to understand why these men behaved in the way they did and therefore help to protect other potential victims. Such an approach fails to consider the combination of personal, cultural and opportunistic factors that are understood to create the conditions for sexual offending[57] including:

- Personal histories and early life experiences
- Attitudes to children and gender, including any familial or cultural component of such attitudes
- Attitudes to sexuality
- Access to vulnerable young people
- Barriers to offending

What we do know in the Rochdale setting, is that many, if not all of these men worked within the night time economy, out of sight of their families, and of much of the wider community. What we do not know is how they were influenced by their experience of culture or how they were able to rationalise what is widely recognised across mainstream cultures as seriously transgressive behaviour.

4.7.27. Although statistical information with regard to sexual offending and ethnicity will always have inherent problems, what is known is that 80.9% of convicted sex offenders in England and Wales are identified as white, and as such focussing on race in isolation is of limited value. Professionals and society need to be aware that sexual offending does exist across all societies and cultures and that a focus which only recognises the possibility for abuse within a particular culture will fail to protect children and young people of all backgrounds. Professionals and the wider public instead need to be alert to the potential for abusive behaviour across communities and develop

[57] See for example, Briggs, D in Calder (2009)

knowledge and confidence in challenging behaviour that suggests acceptable boundaries between adults and young people are being crossed.

4.7.28. Initial consideration was given to the Overview Author seeking meetings with the men to identify any lessons about how they had operated and what if anything could be learnt about prevention as a result. However, it was recognised that this was outside the normal remit of a Serious Case Review and required a separate piece of work if it was to be effective. Both Greater Manchester Police and Greater Manchester Probation Trust are currently undertaking analysis of patterns in relation to the perpetrators' behaviour which is being shared with the Board to increase future understanding.

4.7.29. Whilst it is an uncomfortable conclusion to reach, the evidence suggests that there was a collective failure to recognise that the young people were vulnerable to abuse by a range of men irrespective of race or culture. Not only were services slow to recognise the abuse being perpetrated by the group of 'Asian' men who were convicted at Liverpool Crown Court in May 2012, they were slow to recognise the abuse being perpetrated against them by members of their own families and by AdultD, all of whom were white men.

4.8 The operational response: Responding to the individual and making the links between them.

4.8.1. That agencies responded to the Young People's abuse on a predominantly individualised model for a considerable period had a profound effect on identifying both the victims and the perpetrators. The initial response was damagingly slow to identify and respond to the network of abuse, which necessitated not only a major police investigation but also a co-ordinated multi-agency response. Whilst in theory this network may have been recognised with the production of the report to the Board in 2007, in practice there was little evidence of the impact of this knowledge on service provision to these young people until comparatively recently.

4.8.2. The Crisis Intervention Team from quite an early stage recognised that there was a wider picture beyond the abuse of individual young people. They were able to make links between different men and these and other young people and evidently by 2008 understood that the exploitation was part of a network of men and that the girls were being taken to other towns in Lancashire and Yorkshire to be further exploited.

4.8.3. It is difficult to identify precisely when there was the first clear evidence of a conscious multi-agency operational recognition that the young people were victims of organised child sexual exploitation in Rochdale. There were discussions about sexual exploitation amongst different agencies and references to multi-agency meetings

from early in this timeline. For example In February 2007 there was a record by CIT of a *'Multi-Agency Strategy meeting re multiple abuse of vulnerable young women'*. However there was no further information to confirm the nature of this meeting within the IMRs, who called it or who attended and the only reference to it was by the authority's legal department.

4.8.4. The first point at which there is incontrovertible evidence that the Police and Children's Social Care recognised that the abuse consisted of a number of men abusing a number of young people was in August 2008 when a strategy meeting took place with regard to [redacted] and three other girls. The meeting was chaired by the Independent Reviewing Service as was the second meeting in September of that year. By this point it is explicitly noted that the young people were being sexually exploited. It was also recognised that [redacted] appeared to play some role in coercing the younger girls into sexual activity with the men.

4.8.5. **Strategy meetings.** When meetings did take place there was often a level of confusion about their purpose and how they linked with other procedures. Even the use of the term "Strategy Meeting" was unhelpful as a description of meetings intended to consider a strategic response to CSE as it affected a number of young people. This is the established terminology for the joint investigation processes between Police, Children's Social Care and other appropriate agencies, as part of Section 47 enquiries and Police investigations into possible criminal acts against children. It has been difficult within this Review to identify which function some 'Strategy Meetings' were serving and is likely to have been equally difficult at the time. Neither did there seem to be any pathway for continuing to meet to consider the wider concerns once decisions had been made in relation to the response to the individual young people.

4.8.6. Identifying the multi-agency meetings which specifically considered CSE as a phenomenon relating to more than one individual has proved very difficult given the lack of coherent information across the agencies. For example the meetings in February and April 2007 are only clearly identified in information provided to the Review by the Legal department and were not evident from the IMRs. This lack of transparency and of any robust audit trail recording these meetings will have contributed to confusion at the time as well as in retrospect. The meetings that are understood to have taken place are as follows, but it is not possible to be sure that this is a complete list:

- Three meetings between February and April 2007 regarding 11 young people
- June 2007 Multi agency meeting regarding [redacted]
- Aug/September 2008 2 strategy meetings relating to 6 young people
- March 2010 Sunrise Team Strategy meeting

- April 2010 Child Exploitation Strategy Meeting
- Aug 2010 Multi Agency Strategy meeting at Sunrise.
- 11th February 2011 CSE Strategy Meeting – Police and Children's Social Care

4.8.7. What is apparent is that there was no clear or regular programme of Strategy Meetings prior to the Sunrise team coming into operation and no other means of developing a specific multi-agency approach to CSE. It has been reported by one of the IROs that it had been intended to undertake further Strategy Meetings during 2008 and 2009 in relation to [redacted], but that agencies did not attend. It has not been possible to corroborate this from information provided by other agencies, but whatever the reason, it is evident from the information provided here that there were no recorded meetings between September 2008 and March 2010.

4.8.8. Each of the police investigations beginning in 2008 was attempting to identify the extent of the offences, the victims and the offenders with varying success. However there is no clear evidence that the key agencies, including the police, were systematically mapping the links between the young people and the identified perpetrators as part of an overall multi-agency strategy.

4.8.9. When multi-agency meetings did take place, it is often difficult to identify who attended and why some agencies were involved but not others. For example a multi-agency meeting took place at Middleton Police station, where the Sunrise team was located on 18th August 2010, however no minutes of this meeting are available, apparently because they were withdrawn by the Police. There is no reference to this meeting by the Police themselves. Others, for example, the YOT set up their own meetings, to which they invited other agencies. Frequently these agencies would not then attend, but in the absence of any multi-agency agreement about the status of these meetings, this is not particularly surprising.

4.8.10. Prior to the Sunrise team becoming operational in January 2010, the IROs were required to chair the CSE Strategy meetings. The Review was told by the IROs that this decision was taken by Children's Social Care. No other information has been provided as to who made this decision or on what basis. In the event this was a crucial decision which placed responsibility for the overview and co-ordination of the multi-agency response not even with middle managers, but with practitioners, albeit experienced practitioners. It was absolutely vital that there was leadership of these meetings by senior management. IRO's did not have the authority, the seniority or the power to unlock budgets and other resources which was necessary for these multi-agency meetings to be effective. The decision to use IROs to chair these meetings also suggests that the meetings were viewed as not being fundamentally different to the Strategy Meetings within routine Child Protection process. In other words that at a strategic level there

was a failure to recognise the complexity and significance of CSE within the Borough and the need to adopt a different approach.

4.8.11. Attendance at these meetings was by invitation and again there is no evidence of any lead from strategic managers as to how this would be decided, what the foci of the meetings should be or how strategic managers or the Board would be kept appraised of what was taking place. A number of agencies have identified frustration that they were not invited to these meetings, but there is limited evidence that these concerns were pursued through the Board at the time. .

4.8.12. A further resultant problem was that the IROs felt under increased pressure because of the numbers of Strategy Meetings they were then chairing and the complexity of the cases. It was also clearly minuted at the Sexual Exploitation meeting held in April 2010, that agencies were struggling to respond to CSE due to a lack of basic resources. The IRO who was chairing the meeting stated that "*The lack of resources has led to a situation whereby information gathered cannot progress and there is going to be a delay in addressing the issues. With more resources children would not be at long term continued risk. Outcomes are being improved but not at the level professionals would like".* The IRO also raised serious questions about the level of commitment of Children's Social Care, however there is nothing to suggest that this was consequently taken up with managers.

4.8.13. The key factor in understanding agencies inability to co-ordinate a multi-agency approach without doubt is a result of the absence of Strategic management. Without clear leadership, oversight and access to resources individuals within agencies were faced with an impossible task.

4.9 Concluding comments

4.9.1 Whilst the experience in Rochdale during these years has rightly raised serious concerns at a national level, it would be mistaken to consider that Rochdale was or is unique either in the prevalence of CSE in its community or in the difficulties that agencies experienced in responding to that abuse. The critical Barnardo's report Puppet on a string, published in 2011 concluded that there was a "*shocking lack of awareness that stretches from the frontline of practice to the corridors of government.*" and as such to consider that Rochdale's experience was unique to this Borough would be to fundamentally misunderstand the prevalence of CSE and the slow development of good practice at a national level.

4.9.2 This Review nevertheless has catalogued a widespread pattern of weaknesses and failures both in relation to agencies and to individual practice. These together acted to undermine the system's ability to protect and safeguard the young people over a period of years. The

multi-agency response to the needs of these 6 young people provides a very mixed picture. The key failings in practice are all too evident, although some are much easier to see in hindsight than was the case at the time.

4.9.3 Some practitioners and agencies evidently fell below acceptable practice standards at some times. Many of those mistakes have been recognised and acknowledged both by individuals and by the agencies and have had consequent effects on employment as well as public confidence. There is however also evidence of empathetic, concerned responses by some practitioners who were clearly trying to respond to and build relationships with the young people.

4.9.4 It should also be recognised that harm to the young people was both as a result of the sexual exploitation to which they were subject, but also harm to their welfare as a result of other life and childhood experiences. Successful intervention with the young people to protect them from the corrosive nature of the abuse they were suffering once it had been established could not have been guaranteed, even if best practice had been adopted. However, it is clear that time and again the possibility of such intervention was missed

4.9.5 This however, is on its own merely a description of what went wrong and seen in isolation tells us little about why there was such a significant failure to protect these young people. What has been identified throughout this review is a repeating theme of factors which impacted on the quality of practice in particular including:

- Policy and procedures either not available or poorly understood and implemented at the front line.
- Absence of high quality supervision, challenge and line management oversight
- Resource pressures and high workload in key agencies, including CSC safeguarding teams, A&E, Police, contributing to disorganisation and at times a sense of helplessness.
- Policies, culture and attitudes within many agencies which were actively unhelpful when working with adolescents.
- Performance frameworks focussed on quantitative practice not on quality of practice or understanding the child's journey through services and outcomes.

4.9.6 What is indisputable is that the repeating nature of these failures exposes fundamental problems and obstacles at a strategic level in Rochdale, not simply in relation to individual practice. That the failings took place over a period of 5 years in relation to 6 young people who were in contact with at least 17 different agencies makes it absolutely clear that the problems were much more deep rooted than can be explained as failings at an individual level. It is also important to note that the experiences of these 6 young people whilst fundamentally important in their own right are accepted by agencies within Rochdale as being indicative of the experience of other young people at the time.

What resulted represents a culture and a pattern of leadership that individuals were either unwilling or unable to change.

4.9.7 It is self-evident that the specific areas of weakness as identified in this review require speedy resolution where this has not already been taken, whether this be in relation to individual performance or procedural or policy weaknesses. However focussing on individual weaknesses will simply repeat the patterns of previous learning and reviews, and risks failing to identify the fundamental underlying problem. This problem which time and again has been identified when the Review asked why the identified problems took place brought us back to the following key issues:

- Longstanding failings in leadership and direction at the most senior levels of key agencies
- Longstanding difficulties in achieving effective multi-agency working at the most senior levels reflected in operational practice.
- Failure by strategic managers to focus on routine safeguarding practice, to understand how it was delivered.
- Lack of an evaluative culture focussed on the experience of young people, outcomes and the effectiveness of interventions.
- Under-resourcing resulting in high workloads, decision making influenced significantly on managing budgets to the detriment of practice which would meet children's needs

4.9.8 It is of interest that some agencies, although not without their own problems, seemed able to provide a fundamentally more constructive service to the young people, not least in the capacity of their staff to understand and engage with those young people. The assessment of one panel member, which is worthy of consideration, is that one of the features several of these agencies had in common was *"a foot in the outside world*". From this perspective it would seem that a significant contributory factor to the fundamental weaknesses in practice was that the history and complex dynamic of established agencies within Rochdale had resulted in a level of dysfunction when attempting to work collectively which was stronger than any individual's attempts to untangle it.

4.9.1 **Could the abuse have been predicted or prevented?** In reflecting on whether or not it should have been possible to protect the young people from the abuse they experienced, the answer must be: it should have been possible to have prevented a significant part of the abuse that took place. There were two different routes that should have led to prediction and prevention.

4.9.2 Firstly 5 of the young people were, for several years prior to being sexually exploited, clearly in need of early help and at times intervention by safeguarding agencies to protect them from highly damaging experiences such as neglect, domestic violence, parental mental health problems and substance misuse. Had there been a

properly co-ordinated package of both support and assessment which recognised these risks, it must be possible that the vulnerability of these young people could have been assessed and responded to at a much earlier stage.

4.9.3 Secondly, given the highly organised, determined and manipulative behaviour of the perpetrators, it would be unrealistic to imagine that their behaviour could have been predicted and that all harm to all the young people they abused could have been prevented. However, had the sexual exploitation been recognised and responded to at the earliest stages, these young people may have been protected from repeat victimisation and other young people may also have been protected from becoming victims.

5 MULTI AGENCY RECOMMENDATIONS

5.1. Rochdale Borough Council and agencies responsible for child protection in the Borough have been under considerable scrutiny over the years since these events fully came to light. This Serious Case Review is the latest in a series of reviews that have taken place, each of them with a slightly different focus, but inevitably with many of the same conclusions being drawn. A significant amount of remedial activity has been required both of individual agencies and of the Safeguarding Board in response to the failings identified regarding these 6 Young People, as well as many others.

5.2. Shortly after this Review was initiated the Local Authority was subject to an improvement notice as a result of an OFSTED Inspection which judged the overall effectiveness of the Council's arrangements to protect children to be inadequate. A new CSC Senior Management team was appointed and was taking up post at the point this Overview report was being finalised. The work is still to be completed but it is known that it has been focused on many of the issues that have been considered within this report**.** Other agencies have also been subject to formal scrutiny during the timeframe that this Review was undertaken including an Inspection of Rochdale YOT team. Children's Social Care and Greater Manchester Police agencies have also been dealing with staff performance issues arising out of this review and other reviews of the response to child sexual exploitation.

5.3. In relation to child sexual exploitation, the OFSTED inspection concluded that there had been "steady progress" in the response of the Board to CSE during the previous 2 years. OFSTED noted that there had been:

- Extensive training on risk indicators and triggers with multi-agency staff
- Awareness raising with young people

- Increased identification of young people at risk through the sharing of intelligence between partners
- Increased disruption activity

It is recognised that there is further work to do, and that CSE remains a priority for the Board.

5.4. It is now incumbent on the Board and its members alongside the Local Authority to map the activity that has already taken place, to scrutinise that activity in the light of this review and identify what is already in place or being put in place to meet the gaps and what further action is therefore required. Given the range of bodies that is setting tasks for the Board and its partner agencies a prioritisation exercise by the Board will be vital. The Review has identified the following areas for attention that will need mapping against the activity already in train:

- Prioritisation of CSE by the LSCB including tracking of the link between strategic intentions and operational outcomes.
- Reviewing the current state of understanding, identification and practice regarding CSE across agencies, including the effectiveness of Child Protection processes for the victims of CSE.
- Early intervention
- Improving understanding and responding to neglect across the age range.
- Improving non-specialist understanding of learning disability/difficulties
- Maximising the engagement of Board members in its task
- Joint planning with the Local Authority for community development regarding CSE.
- Review at both strategic and practice level of the degree to which services embed adequate understanding of local communities and cultures.
- Review and develop a skill and knowledge base for practice in relation to working with adolescents.
- Development of agency and practice skills and confidence in working in a diverse community.
- Review of escalation policies and their effectiveness and work on inter agency professional challenge
- Qualitative and outcome based assessment of functioning of the Sunrise team.

However this Review is firmly of the view that it is the foundations of good multi-agency child protection practice that the Board and its partners need to

focus on with greatest care if the areas of weakness which have been identified can be effectively addressed.

Multi-Agency Recommendation 1:

In the light of the areas of weakness identified within this Review Rochdale Safeguarding Children Board (RBSCB) to map and scrutinise work on practice improvement that has already taken place and identify what further action is now required.

Multi-Agency Recommendation 2:

RBSCB to put in place independent measures to test the extent to which the restructuring of the Board and other related developmental activity has led to improvements in multi-agency working at all levels.

Multi-Agency Recommendation 3:

As a matter of urgency RBSCB to seek evidenced confirmation from each of its partner agencies that they are fulfilling their Section 11[58] requirements as set out in Working Together to Safeguard Children (2013).

Multi-Agency Recommendation 4:

RBSCB to establish a framework for direct communication between the Board, service users and front line practitioners in order to develop a shared understanding of the way in which services are provided to children ; the strengths, vulnerabilities and effectiveness of front line practice; and the impact on outcomes for children.

Multi-Agency Recommendation 5:

The Board to review the skills, knowledge base and priority partner agencies afford to working with Adolescents.

[58] Section 11 of the Children Act 2004 places duties on a range of organisations to ensure their services are discharged with regard to the need to safeguard and promote the welfare of children.

6 INDIVIDUAL AGENCY SUMMARY OF INVOLVEMENT, REPORTS AND RECOMMENDATIONS

A brief overview of the involvement and key issues identified in relation to each agency is provided in this section. All of the agencies through the production of their IMRs have identified learning and provided recommendations for their agency as follows:

6.1 Action for Children

Action for Children has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Head of Safeguarding. The author has had no operational responsibility in the case nor any direct involvement with the Young People or their families and as such met the criteria for independence.

The Report was countersigned by the Director for Practice Improvement. The countersigner had no direct knowledge or involvement with the services provided to the young people or their family.

6.1.1. Action for Children provided supported housing and tenancy support services for [redacted] the longest involvement being with [redacted] who remained at the project for nearly a year, whereas [redacted] and remained only a matter of months. The young people were in the same facility but at different times. Action for Children staff were aware at the point of referral that [redacted] had probably been subject to sexual exploitation, but did not have similar information regarding [redacted] and [redacted] on referral. The project generally liaised as required with other agencies, complied with policies and procedures and attempted to engage and support the young women

6.1.2. The IMR appropriately identified both strengths and areas for improvement in their practice and linked these clearly to learning and recommendations. In particular it recognises that there were occasions with hindsight when concerns about [redacted]s vulnerability and the possibility that she was being sexually exploited should have been discussed with Children's Social Care, or the police. It would appear that the agency understanding of Child Sexual Exploitation was developing during the period and there was a clearer understanding of the issue within the project in relation to [redacted]. It was also identified that the individual actions were taken to improve the safety of the young women, but that this tended to be reactive and there was no recognition at the time of the possibility that the project might be targeted by men for sexual exploitation.

6.1.3. The **recommendations** for action for Action for Children are as follows:

1: Action for Children should understand the scale and nature of concerns around CSE being faced by our services. Relevant services should be supported in increasing their ability to recognise child sexual exploitation.
Staff in services where Action for Children support or provide tenancies to vulnerable young people, similar to SHS1, should be given the opportunity to consider the following issues;

- Thresholds for referral to statutory agencies, including Children's Services.
- Assessment of need of those referred to the service and ensuring that the service offered addresses these needs.
- Consideration of practice in identifying risk of sexual exploitation and domestic violence.
- Issues relating to ethnicity and vulnerability to sexual exploitation.
- Consideration of the use of tenancy warnings.

2: To ensure a consistency of knowledge and understanding of child sexual exploitation within Action for Children, all relevant staff should receive specific learning and development on Child Sexual Exploitation.

3: Action for Children should review and amend all relevant internal reporting processes to ensure that they address Child Sexual Exploitation.

4: The information and learning from this review would be of benefit to all operational staff. To ensure that this takes place all organisational Safeguarding meetings should be briefed on the learning from this review.

5: A review of Action for Children's Retention and Destruction of Records Policy should take place to consider any changes needed and carry out any relevant actions***.***

6: Action for Children should review and implement any changes necessary to their policy, procedure and guidance with regards to child sexual exploitation.

7: Action for Children ensure that all services that provide supported lodgings, addresses young people who are missing in a way that is consistent with regulated services.

6.1.4 Action for Children provided the following information in relation to actions already taken arising out of this review:

Action for Children has delivered workshops on CSE at all its safeguarding meetings at both organisational and divisional level. We have undertaken an exercise to establish the amount of CSE

all our services our experiencing, and will be using this to focus our strategy for increasing the skills needed to deal with CSE amongst our varying services. We have ensured that all of our staff have been made aware of the issues of CSE and how this might affect their service users. We have made changes to a number of our policies to support positive practice across our many services. We have also started the commissioning process to deliver training to targeted groups of staff across the organisation."

6.2 Barnardo's

Barnardo's has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Assistant Director, Children's Services, North West. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families, and as such met the criteria for independence.

The Report was countersigned by the Assistant Director of Children's Services, Cumbria, who had no direct knowledge or involvement with the services provided the Young People.

6.2.1. Barnardo's provided a short term Resettlement Support Service (Fresh Roots) to [redacted] for a period of 7 months during 2009 and 2010, to [redacted] for a period of 4 months in 2010, and a residential placement for [redacted] for 2 months in 2011. Work with [redacted] was in relation to practical problems and finished due to her lack of engagement. No information was provided to the project that would have alerted it to child sexual exploitation in relation to [redacted] The project worker allocated to [redacted] had information about domestic abuse and there are some gaps in information as to how this was responded to. The accommodation provided for [redacted] was outside of Rochdale specifically in response to her being a victim of sexual exploitation. [redacted] tenancy was ended due to her alcohol use and its effect on her behaviour to other residents and staff.

6.2.2. Barnardo's IMR acknowledges that despite its organisational knowledge about CSE at a national staff in these projects did not have particular awareness or expertise. This was felt, in part, to be as this was an adult rather than a child focussed service. Barnardo's no longer runs this service and has now decided not to engage in similar projects in the future. It has nevertheless has identified general organisational learning for its recommendations.

6.2.3. The **recommendations** for action for Barnardo's are as follows:

1. All project workers and team managers in the NW region to have CSE training.

2. The regional CSE services to review cases where service users have a learning disability.
3. All NW services to ensure that service referral forms and risk assessments take into account any issues of Domestic abuse
4. Lone worker policy to be reviewed at Rachel House
5. Rachel House to review monitoring system for updated risk assessments.

6.2.6 Barnardo's has provided the following information in relation to actions already taken arising out of this review:

1 Managers from Barnardo's CSE service have implemented training for team managers in the NW Regions. Training of project workers from generic services has commenced and the implementation will continue to be implemented across 2013 and early 2014.

2 Specialist services have concluded a review. A group involving staff working across CSE and disability issues has been formed to review the suitability of practice materials as a result of this review.

3 A group have been formed to given consideration to the current domestic abuse risk assessment framework used for 1:1 case work. A revised version of this documentation is being developed which will incorporate the recommendation.

4 Lone worker Policy has been reviewed and an updated policy has been in place since July 2013

5 Risk assessments updated and new review arrangements are in place from July 2013

6.3 CAFCASS

CAFCASS has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Service Manager, National Improvement Service. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Head of Service (Corporate Services). The countersigner had no knowledge or involvement of the services provided to the Young People and their families.

6.3.1. Children's Guardians from CAFCASS had involvement with [redacted]. With the exception of [redacted], the role of CAFCASS was to represent the children of the Young People in Care Proceedings and to assess the Young People's parenting capacity.

CAFCASS was appointed to represent [redacted] when Care Proceedings were taken in relation to her. On each occasion, it was already identified that the Young People had been subject to sexual exploitation. The fact that there were links between the young people was not directly relevant to the role of CAFCASS, who are required to consider the needs of the individual child within proceedings.

6.3.2. The service provided by CAFCASS was of the expected standard. The IMR has identified some general learning with regards to the impact of Child Sexual Exploitation for victims who then become parents and makes an appropriate recommendation.

6.3.3. The **recommendation** for action for CAFCASS is as follows:

1. To develop and mandate the use by professional staff an e-learning module on child sexual exploitation, incorporating learning from this SCR (together with other SCRs to which CAFCASS is contributing and literature/research).

5.3.5 CAFCASS has provided the following information in relation to actions already taken as a result of this Review:

> The e – learning module is well underway but not yet completed. Nationally the Head of Service (Corporate Services) is also preparing an update to his presentation learning from SCRs which is delivered to all teams by local Service Managers.

6.4 CONNEXIONS

Connexions Rochdale has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Service Manager. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the *local Connexions Manager.* The countersigner had no knowledge or involvement of the services provided to the Young People and their families.

6.4.1. Connexions Rochdale provided Education/Training and Employment advice and support to all the young people subject to this Review. The service included routine careers advice within schools as well as more individualised support. Connexions only had knowledge that Child Sexual Exploitation was a concern in relation to three of the young people, having been told specifically either by the young person themselves or by other professionals. It is acknowledged that there was other information that might now be understood as warning signs, such as early teenage pregnancy. However in the context of their role and limited information it would not be reasonable to judge that Connexions should have identified the information earlier. There

is recognition by Connexions that CSE was not an issue which was well understood at the time and acknowledgement that the agency has learnt from the experiences of these young people.

6.4.2. Connexions workers generally met their service standards; they demonstrated a degree of persistence in their attempts to engage with the young people and proactive liaison with other agencies. There is evidence of meaningful line management involvement and that safeguarding procedures were followed. Connexions has identified some inconsistencies in practice including: not confirming information provided by young people with other services and making assumptions that statutory services were aware of information; on one occasion an advisor failing to refer to the historical case file.

6.4.3. The **recommendations** for action for Connexions Rochdale are as follows:

1. Where information about a client is received from or passed on to another agency, a key contact from that agency should be identified and any information received/actions requires should be routinely followed up.
2. Client intervention notes and information received from/passed on to other agencies need to be thorough and detailed to ensure other workers that conduct future interventions have a clear understanding of clients' circumstances. Additionally it is vital that time is taken prior to an intervention to read previous contact details.
3. Lessons learnt from the SCR to be presented to all Positive Steps Advisers/Managers as part of Refresher CSE Training.

6.4.4. Connexions has provided the following information in relation to actions already taken as a result of this Review:

- Since the move over from Careers Solutions/Connexions to Positive Steps in April this year, Positive Steps is currently undertaking a review safeguarding policies and procedures and staff training requirements/refresher training to ensure there is a consistency of practice / level of understanding following the acquisition of both the Rochdale and Tameside contracts. Approach to CSE will be a key feature of this, and the Action Plan submitted in relation to IMR 1-6 and IMR 7, will be incorporated into the process. There will specifically be refresher CSE training following the conclusion of this SCR.
- In the meantime, a primary feature of the Action Plan following IMR 1-6 was the need to identify key contacts from other agencies where information was either passed on or received and any actions required should be routinely followed up. In addition, the need to ensure client intervention notes were clear and thorough enough to ensure effective continuity of practice should alternative Advisers become engaged with the client, is being monitored via the process of verification audits being conducted by Team

Managers on client records completed by Advisers and via monthly Caseload Management reviews conducted every 6 weeks.:

6.5 Crown Prosecution Service (CPS)

The Crown Prosecution Service has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by a recently retired Deputy Director of the CPS Special Crime Division. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Chief Crown Prosecutor CPS North West having been agreed by the Director of Public Prosecutions (DPP). The countersigner had no knowledge or involvement of the services provided to the Young People and their families prior to June 2011, when he made the decision to prosecute the men who were later convicted of offences against the girls. Given the oversight of the DPP however, the panel was satisfied that the criteria for independence is met.

6.5.1. The CPS provided advice and authorisation to the police regarding criminal charges relating to [redacted] as well as other victims of child sexual exploitation within Rochdale as part of Operation Span.

6.5.2. The Crown Prosecution Service had no previous experience of involvement in a Serious Case Review and was initially unfamiliar with the expectations. The CPS was also hampered in its analysis by its file retention policy which meant that they were significantly reliant on information provided to them by the police as a number of their own files had been destroyed. However an independent author was ultimately commissioned and undertook a thorough and critical review of the work undertaken by the service.

6.5.3. Recognition of CSE in relation to the young people by the CPS in the early years was very poor. As a result a significant opportunity to prosecute some of the men concerned following allegations made in 2008 was missed and this had a direct impact on the willingness of at least one of the Young People to trust the criminal justice system in subsequent years. The agency has been very open both publicly and within this Review regarding its failings at this time but has since demonstrated considerable changes in both approach and practice and high level strategic leadership.

6.5.4. The CPS practice in relation to [redacted] effectively highlights the stark difference between good and poor practice in relation to vulnerable young people experiencing sexual exploitation. Two particularly significant lessons for the CPS are recognised:

- The successful prosecutions in 2012 can be seen as a model for how to build a constructive case leading to conviction in comparison with the approach to the allegations in 2008/9.
- An approach which focuses on victims' troubled backgrounds or inconsistent responses as a reason to doubt their credibility fails to understand that issues such as this are a feature of their vulnerability to abuse. Prosecutors are now encouraged to " *build a case which looks more widely at the credibility of the overall allegation rather than focusing primarily on the credibility and/or reliability of the child or young person*"

6.5.5. As a result of a number of high profile sexual abuse cases, including the experience of YP1-6, the CPS has begun a series of major changes to its practice in relation to sexual abuse. Recommendations made within the CPS IMR will be contributing to these changes.

6.5.6. The **recommendations** for action for the CPS are as follows:

1. CPS to draft new prosecution specific guidance on sexual offences concerning children.
2. A training package is to be prepared, delivering practical advice and guidance to front line police and prosecutors dealing with child sexual exploitation cases.
3. A national network of Child Sexual Abuse trained prosecutors is to be established with Nazir Afzal as the CPS Champion.
4. Guidance be produced as to the material to be considered when a second opinion is sought and that the Advice Review Checklist to be written to reflect national CPs policy.
5. The CPS should review its policy on file retention to see whether the current guidelines are adequate.

6.5.7. The CPS included information regarding actions taken as a result of this Review within the body of the report. The following additional information has also been provided:

> As a direct result of Operations Span and Bullfinch (the "Oxfordshire Grooming Case") the Director of Public Prosecutions has issued Guidelines on Prosecuting Cases of Child Sexual Abuse. A training aid has been distributed to managers in the North West Area. In addition this aid has been circulated to a national network of CPS prosecutors so that lessons learnt locally can be of benefit nationally.

6.6 Children's Social Care (Targeted Services)

Rochdale Children's Social Care (Targeted Services) has provided a chronology and Individual Management Review for this Serious Case Review.

The report has been prepared by an Independent Safeguarding Adviser. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Interim Assistant Director for Rochdale Children's Social Care. The countersigner had no knowledge or involvement of the services provided to the Young People and their families. Subsequently Children's Social Care re-considered the report and concluded that it failed to analyse a number of key aspects of the service's work. The Independent Author was not willing to make changes at what was a very late stage and the Panel agreed that CSC could provide an additional document, alongside, not instead of, the IMR already produced. This document, whose purpose was to highlight further areas of learning, was undertaken by a new Interim Assistant Director who had not had previous involvement with the case.

It is of concern that the IMR countersigning process had not been effective, probably reflecting Children's Social Care continuing difficulties in committing adequate time and resources to the SCR process, in the context of other demands on that agency. The decision to provide a further report has however ultimately demonstrated awareness by CSC of the breadth of improvements in practice required as a result of this Review and a willingness to acknowledge these openly.

6.6.1. As had been anticipated by Children's Social Care given previous reviews of their involvement with CSE, significant weaknesses in the service provided to these 6 young people have been identified in some detail. It is unfortunate that there are some important gaps in information and it is not always clear whether these represent a gap in recording, a lack of activity or that the information was not included in the IMR. Despite these gaps, there is considerable evidence about repeating key themes in CSC's response to these young people and

6.6.2. Children's Social Care had involvement with all 6 of the young people at varying times:

6.6.3. [redacted] and their family are first known to have come to the attention of Children's Services in 2004. The first record of a referral to Children's Social Care regarding the oldest child, [redacted], was in March 2004, although there is no reference to this in the information provided by CSC themselves. [redacted] was subject to a number of Initial Assessments and received Family Support Services, but was never considered a child at risk of serious harm and therefore was not subject to a Child Protection Plan.

6.6.4. A referral was made to Children's Social Care in relation to [redacted] in January 2007 as a result of which Family Support was offered. There were a number of subsequent referrals but from the beginning of 2008 CSC involvement was focussed on [redacted]'s parenting capacity in relation to her child. She was never herself identified as a child at risk of significant harm.

6.6.5. [redacted] first became known to CSC in September 2007 when she was pregnant with [redacted]. The focus of CSC involvement was in relation to her child who was [redacted]

6.6.6. [redacted] CSC first had contact with [redacted] in August 2008 following a referral from the police and was subject to an Initial Assessment. No further safeguarding action was taken but she had contact with the Family Support Team. There was further contact as a result of an Initial Assessment in October 2008, which resulted in referral to Family Support until January 2009. This was followed in February 2009 by a pre-birth assessment. Initial Assessments took place in February and September 2010 the second of which led to further referral for short term Family Support. In January 2011 another Initial Assessment was undertaken leading to a S47 Core Assessment in relation to [redacted] child and later to Child Protection plan, but no further action for [redacted] herself.

6.6.7. [redacted] Children's Social Care in Rochdale first had involvement with [redacted] when the family moved from AreaD and the children were transferred in on a Child Protection Plan in January 2005. The case was closed at the end of 2005 and the next contact was an Initial Assessment in March 2007 regarding [redacted] but no ongoing contact with CSC. Another Initial Assessment was completed in 2008, it would appear in relation to both children, although this is not explicitly identified. [redacted] was assessed as a Child in Need under S17 of the Children Act, but the subsequent involvement by CSC is not made explicit. The next contact was August 2008, when two Initial assessments were undertaken and in October both girls were made subject to Child Protection Plans. [redacted] remained on the plan throughout the remaining period under consideration; [redacted]'s plan was discharged in November 2009. [redacted] had further involvement with CSC in 2010 in relation to her own child who was also placed on a Child Protection Plan.

6.6.8. The IMR openly identifies a significant number of failings in practice both at a practice and a strategic level, these are commented on in some detail within the body of the Overview Report, but include:

- Lack of organisational priority regarding CSE
- An unstable Duty and Assessment team and a chaotic duty system
- Lack of staff training in awareness and recognition of CSE
- Focus on intra-familial sexual abuse as the responsibility of CSC and PPIU and extra ('Stranger') familial abuse as the province of the Police,
- Poor multi-agency working and ineffective information sharing
- Failure to make links and identify networks with victims and perpetrators
- Prejudicial value judgments at an institutional and individual level
- Failure by professionals to understand the dynamics of power imbalances inherent in child sexual exploitation.

- the timeliness and quality of intervention to safeguard them from child sexual exploitation was inadequate

6.6.9. The **recommendations** for action for Children's Social Care are as follows:

1. That addressing child sexual exploitation remains a top priority for Children's Social Care by including it in the agency's annual business plan

2. That a CSC performance management and quality assurance/audit framework be developed and implemented into the effectiveness of the current arrangements for recognising and responding to Child Sexual Exploitation in Rochdale ,that includes the work of the Sunrise Team, and for the results to be reported to the Children's Services Senior Management and the RBSCB.

3. That all Children's Social Care practitioners, first and second line managers, new workers and agency staff have received training in the dynamics of child sexual exploitation, are aware of current policies and procedures and are able to recognise it and intervene appropriately.

4. That child sexual exploitation training addresses with CSC professionals any prejudices or negative stereotyping in their work with child sexual exploitation victims.

5. That child sexual exploitation training includes awareness that learning difficulties and disabilities can be a factor in a young person's vulnerability and for this to be included at an early stage in any assessment of need and risk.

6. That arrangements are made for young people to participate in the safeguarding process and that they are seen and spoken to and their wishes and feelings ascertained in a timely manner.

7. That CSC consider the efficacy of, where appropriate, placing young people at risk of child sexual exploitation who have young children, with 'special' foster carers as an alternative to semi-independent living accommodation.

8. That policy and practice maintains a twin safeguarding focus on both the young person at risk of CSE as a parent and the child of the young person.

9. That CSC incorporates all relevant lessons from the Derby SCR (2010) into its current learning around policy and practice in regard to child sexual exploitation.

10. That CSC incorporates any relevant learning and good practice into its current learning around policy and practice in regard to child sexual exploitation from other 'Good Practice' LSCBs/CSCs and groups such as:The National Working Group for Sexually Exploited Children and Young People'

6.6.10. Children's Social Care, as a result of the supplementary report that was produced after the completion of the IMR have also identified two further recommendations:

1. Prioritise the on-going training and development of practitioners and managers in the early identification, assessment of neglect and the adoption of effective evidence based interventions.
2. The development and implementation of supervisor development programme which focusses on the on the delivery of effective casework supervision.

6.6.11. Children's Social Care has provided the following information in relation to actions already taken arising out of this review:

- The effective and early identification and addressing of child sexual exploitation is a top priority of local authority and is included in the Service Improvement Plan and the CSE Strategy which are reported to the Children's Safeguarding Board
- A new quality assurance framework has been developed and is in place. This framework which uses auditing, direct observation and service user feedback includes testing the effectiveness of recognising and responding to Child Sexual Exploitation.
- The training of all practitioners and managers in recognition, assessment and response to child sexual exploitation has been completed and is now part of the mandatory induction programme for all news starters.
- This training addresses possible belief systems about child sexual exploitation, the dynamics involved and the role that learning difficulties can play as vulnerability factor.
- All children referred to Children's Social Care are screened for risk for child sexual exploitation.
- Revised arrangements ensure that the young people are now properly supported to engage with the safeguarding processes and their wishes and feelings are sought.
- The development of a bespoke placement service for vulnerable young people who are at risk of CSE is being led by the Local Authority Commissioning Manager for Placements.

6.7 Children's Social Care – Children's Safeguarding Unit

Children's Social Care Children's Safeguarding Unit (IRO Reviewing Service) has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by an Independent Consultant in Child Protection. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Service Manager, Children's Safeguarding Unit. The countersigner had no knowledge or involvement of the services provided to the Young People and their families as she was not in post at the time of the events under Review.

6.7.1. The Safeguarding Children Unit within Children's Social Care was responsible for providing Independent Reviewing Officers (IROs) for Looked After Children reviews and Chairs for Child Protection Conferences and Reviews. The Reviewing Service was involved with 4 of the young people and, [redacted] children. The IROs also undertook the role of Chair for some of the Sexual Exploitation Strategy Meetings held in relation to a larger group of young people. The IMR has clearly outlined a range of gaps and failings in the IROs' practice which contributed to the ineffective nature of the response by the multi-agency group who were attempting to assess and protect these young people through formal procedures. In particular it concludes that:

- There was frequently a difference of perspective between the Reviewing Service and the professionals involved in Child Protection Conferences and Reviews as to how to respond to the young people. However the IROs were unable to challenge this effectively, not least because of the lack of power of their role culturally and within the organisation at that time.
- The Safeguarding Unit IROs did not have the expertise, resources or status to properly manage the strategic meetings regarding CSE which they were required to chair.
- There was a marked lack of challenge by IROs both about the progress of individual cases and of the strategic response of Children's Social Care more widely.

6.7.2. The IMR provides clear recommendations and direction to the Safeguarding Unit as to the improvements required.

6.7.3. The **recommendations** for action for the Children's Safeguarding Unit are as follows:

1. The Safeguarding Unit IRO Service needs clarification of their role and further development of their quality assurance role.

2. The specific role of the Reviewing Officers in “Strategy Meetings” should be clarified.

3. Management arrangements need to be in place to ensure that there is an appropriate escalation within the Reviewing Service, when there are concerns about safeguarding issues.

4. Child Protection Plans should not be discontinued at the first CP Review, or if the core assessment has not been completed, unless there are alternative legal plans in place to safeguard children.

5. Children who have been or are being sexually exploited should be assessed as children in need or in need of protection and offered services to support them where appropriate.

6. There should be a clear distinction between safeguarding plans for young mothers who have been sexually exploited and CP Plans for their children.

7. Child Protection Conferences should ensure that information about historical abuse is available to the Conference.

6.7.4. The Children’s Safeguarding Unit has provided the following information in relation to actions already taken arising out of this review:

Within the timeframe of the review and since, there has been a number of changes at the safeguarding unit which correspond with recommendations made within the review:

1. A new agenda and template of minutes for conferences provides greater scrutiny of child protection cases and to the wishes and voice of the child or young person. It also ensures children are discussed separately and that specific recommendations are SMART so decision making is more robustly tracked.
2. The safeguarding unit is also piloting a separation of chairing roles so there are now designated chairs for CP conferences and IRO’s for LAC reviews. This pilot started in September and will be evaluated in January. This is to look at whether developing specific expertise will better support the new escalation processes agreed for child protection and allow for a stronger quality assurance framework around conferencing
3. The advocacy service for Rochdale children has been extended to support children who are subject to child protection plans and the advocate has supported children to either attend conference or to

have their views clearly stated. Reports from the advocate are produced with recommendations for the senior leadership team.

4. The unit has also appointed a quality assurance officer who has introduced a new quality assurance framework to ensure that there is regular feedback from both conferences and from looked after reviews for, children and parents. The reports produced from this feedback are shared at senior management team meetings to ensure that gaps in service are addressed and themes are reviewed again at regular intervals to examine progress.
5. The unit has increased its capacity with the introduction of a team manager for the IRO and conference review service and three additional IRO's to ensure that case loads reflect recommendations within the IRO handbook and IRO's are able to greater develop their quality assurance and challenge role.
6. The unit has also introduced an escalation procedure in relation to child protection conferences and has reviewed the dispute policy for looked after children. As a result a new section within the recording system of ICS has been added so that IRO's and conference chairs can now record escalations directly on the child's file for both child protection and looked after reviews. Monthly reports of the escalations are produced and themes are identified and actions agreed via the senior management team.

6.8 Early Break

Early Break has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Business Manager for East Lancashire. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Chief Executive. The countersigner had some limited involvement as a line manager of one of the workers, but there is no evidence to suggest that this has impacted on the role's independence.

6.8.1. Early Break is a specialist young people's drug and alcohol service and had involvement with [redacted] during the time period for this Review. Early Break had fairly limited involvement with [redacted], who referred herself to the service wanting to talk about the impact of her father's heroin use, but only kept two of the 5 appointments offered and did not respond to attempts to contact her. During one of the appointments [redacted] was also seen, though it is not identified which one.[redacted] was referred to the service by her school. An Early Break worker who was seconded to the YOT team worked with her, but had little contact with her as she did not keep appointments.

[redacted] was referred to Early Break by Accident and Emergency following an overdose, but did not respond to attempts to contact her.

6.8.2. Early Break's main contact was with [redacted] who was initially referred to them by her school, but did not take up the referral. 2 years later she was re-referred by an Early Break Outreach worker, when she did engage with the service. There is evidence of a good level of support being offered to her combined with clarity about the safeguarding implications for her and her child, during a period when [redacted] was experiencing significant distress. [redacted] had spoken about the sexual exploitation at an early stage and this was a major focus of the service's intervention. It would appear from her response to staff that they were able to establish a trusting and positive relationship with her. The Early Break worker also fulfilled an advocacy role for [redacted] in relation to formal proceedings for her child.

6.8.3. Early Break identified considerable frustration amongst their staff about what they believed was the unwillingness of statutory agencies, particularly Children's Social Care, to properly keep them informed and treat them as partners, particularly Children's Social Care. Reflecting on how the organisation could have escalated and responded to this has been a key learning point for the agency.

6.8.4. Early Break was mostly confident about the organisation's awareness and recognition of Child Sexual Exploitation both at the time and currently

6.8.5. The **recommendations** for action for Early Break are as follows:

1. Early Break to establish a formal process for the dissemination of learning from SCR
2. Early Break to review its current locality based process for recording and reporting of CSE. These to be recorded in one central place and the workforce to be updated on them.
3. Early Break's workforce to reflect on their own organisational culture and how they also experience other organisational cultures in relation to CSE. Workers to also identify areas of tension and explore these in relevant supportive forums e.g. supervision
4. Early Break to establish clear escalation processes for safeguarding issues and complaints about other organisations
5. To share the good practice identified with [redacted] with the Early Break workforce and how this matches current recommended practice
6. Early Break workers to undertake training on power in relationships and apply learning to all cases especially CSE ones.
7. Early Break to review how it works alongside the YOT. To specifically focus on statutory and voluntary appointments and how and where the service is delivered from

6.8.6. Early Break provided the following information in relation to actions already taken arising out of this review:

- Each geographical area has met and discussed CSE how they would identify it, who they would speak to and who they would report to. This is an on-going piece of work and we aim to develop an area guide for each locality, overseen by our operational managers.
- A safeguarding escalation process has been written. This is currently going through the service Clinical Governance framework for ratification.
- A process pathway has been developed for the service in relation to learning from SCR and how this learning is disseminated across the service. This is also awaiting ratification.
- A full service training event is occurring on the 6th September 2013 which is being led by the service appointed CSE workers who are based within the CSE teams in our respective areas. This training will build on previous service training events on CSE.
- Audits have been undertaken on case work recording, good practice and individual feedback has been shared with all staff

6.9 Education Welfare Service

6.9.1. Rochdale Borough Education Welfare Service has provided a chronology and Individual Management Review for this Serious Case Review.

6.9.2. The report has been prepared by a School Improvement Officer, who is not a member of the Education Welfare Service The author has had no operational responsibility in the case or any direct involvement with the Young People and their families, and as such met the criteria for independence.

6.9.3. The Report was countersigned by the Senior School Improvement Manager who had no direct knowledge or involvement with the services provided the Young People.

6.9.4. The Education Welfare Service had no involvement with [redacted] during the timeline of this Review, but did have contact with all three previously and noted them as having attended school erratically and not being easy to engage with. The Service did have contact with [redacted] and their family during the time period. [redacted] was of particular concern in that she had significant levels of absence from school and this eventually led to the involvement of the IMPACT (Improving Attendance Co-ordination) Team and

consideration, but not activation of legal proceedings against [redacted]. Reference to [redacted] is largely in relation to her sister and there is no evidence of direct work with her in her own right. There is little information about involvement with [redacted] whose attendance was also low, but there is reference to her siblings also being known to the Education Welfare Service.

6.9.5. The IMR's analysis was seriously undermined by problems with the quality of and frequency of recording. For example, the author was unable to establish the service's level of understanding of Child Sexual Exploitation, but notes that there was no evidence of any strategic approach to CSE at that time.

6.9.6. The IMR specifically identified unacceptable practice within the study centres whereby young people were registered using inaccurate codes suggesting they were present, when in fact they were not. This was identified during an inspection in 2009 and clear instruction given as to the proper use of codes.

6.9.7. The two most significant lessons for the Education Welfare Service:

- Significant problems with the accuracy and quality of recordings and resultant impact on the service's ability to review practice, analyse its effectiveness or track the progress of referrals to other services and therefore whether there is a need to escalate any concerns.
- The practice of using attendance codes at school learning centres in a way which was misleading

6.9.8. These and other areas for improvement are appropriately subject to recommendations

6.9.9. The **recommendations** for action for the Education Welfare Service are as follows:

1. All pupil files whether paper or electronic must contain sufficient detail including full names of adults and their job titles to enable support and supervision meetings to evaluate the impact of the work being carried out, to make accurate and well informed decisions as to necessary referrals and to embed good practice identified across the service. Discussions which are held informally should always be logged.

2. Support and supervision sessions should be maintained at their current frequency but should include a focus on recording what has been successful, possible through a case study model, to enable the embedding of successful practice and to promote reflection in other challenging cases. The current effective practice in support and supervision should be developed into a fit for purpose case management process.

3. A challenge and escalation policy should be established to ensure consistent good practice and confidence in resolving issues where

partner agencies, including schools are not seen to be working in the best interests of children and young people.

4. Service policy and practice should enable all service members maintain a focus on the wider welfare of young people in order to have a holistic view of their well-being.

5. A focus on training and monitoring schools in the use of code 'B' in registers to ensure its use is appropriate and accurate.

6.9.10 The Education Welfare Service has provided the following information in relation to actions already taken arising out of this review:

Recommendation 1: Education Welfare Staff have undertaken training in the summer term 2013 on the required recording standards in the Education Welfare Service. All EWS case files are now electronic and all interventions are now logged on individual pupil log sheets. Standards for recording will be monitored during supervision sessions and there will be regular dip samples of case files to ensure recording standards have been embedded.

Recommendation 2: Supervision sessions continue to be maintained at the current level; however the reduction of Senior EWOs within the service may impact on this action point.

Recommendation 3:. The policy will form part of the wider 'Education' challenge and escalation policy which is currently being developed by the Education Safeguarding Officer in conjunction with the EWS, schools' partnership and Head of Schools. This deadline for the action point will need to be extended.

Recommendation 4:. Work is being undertaken to look at the best ways to gain feedback from young people and their families about the holistic approach to young people and families by officers in the Education Welfare Service. The service is currently working with advocates within the Stronger Families programme.

Recommendation 5:. The monitoring of schools use of the 'B' code continues to be challenged by staff within the service and escalated to senior management team for intervention. Further action on this will be explored in Attendance Leaders meetings which are due to be set up during the Autumn Term 2013.

6.10 GP Services

The GP Service has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Clinical Lead for Safeguarding, NHS Heywood, Middleton and Rochdale Clinical Commissioning Group, also a GP. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families, and as such met the criteria for independence.

The Report was countersigned by the Executive Nurse for the Clinical Commissioning Group, who had no direct knowledge or involvement with the services provided the Young People.

6.10.1. The Young people were registered at different times with 4 GP practices and sought consultation and treatment for a range of needs including sexual health, ante-natal care, mental health and chronic illnesses. GPs were also provided with routine information from other health services, including CAMHS and A&E about the young people.

6.10.2. GP services had explicit information that [redacted] were at risk of sexual exploitation after 2007. The GPs also had significant information that could have helped them identify the possibility of sexual exploitation at earlier points and in relation to [redacted]. However there appeared to be a lack of knowledge about CSE and the focus on clinical responses rather than holistic responses means that the young people's wider safeguarding needs were generally not recognised.

6.10.3. The review of the GP Services has identified the following key lessons:

- need to consider not only the clinical but the wider needs of young people presenting with sexual health needs
- lack of recognition by GPs of indicators of sexual abuse in young people
- The need for better understanding of sexual abuse generally and CSE more specifically
- Improved understanding of role of GPs in child protection and when action is required.

6.10.4. The **recommendations** for action for GP Services are as follows:

1. The Pan Manchester Protocol for the Management of Sexually Active Young People under the age of 18 years needs to be distributed to all GP surgeries in the borough with audit to be completed after six months to ensure that policy is embedded into practice.
2. Training in CSE and child protection for GPs needs to be reviewed to ensure that key risk indicators are recognised and the role of the GP is emphasised. Recognition of child abuse as a differential diagnosis also needs to be included. Safeguarding training for GPs

needs to be audited to ensure that outcomes of training are changing clinical practice.

6.10.5. The GP Service has not provided information in relation to actions already taken arising out of this review

6.11 Greater Manchester Police

Greater Manchester Police have provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by two Review Officers and the Force Review Officer working as a team. The authors had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by a Detective Chief Superintendent, Head of the Public Protection Division who had no direct knowledge or involvement with the services provided to the young people and their families.

6.11.1. Greater Manchester Police IMR has robustly and openly identified a number of significant concerns about the response of the Force to these young people. These include:

- A failure to recognise Child Sexual Exploitation in the early stages.
- Individual decision making that with hindsight has been recognised as flawed eg the absence of challenge to the CPS decision not to prosecute in 2009
- Lack of resources and managerial support for the investigations initially led by CID in August 2008 and later by the PPIU, despite the officers in both cases formally seeking further resources and help.
- The use of CID officers without training or familiarity with safeguarding and partnership working to investigate child sexual exploitation cases.
- Lack of managerial oversight and challenge in relation to the investigations in 2008 and 2009.
- A lack of strategies to respond to frequent ‘runaways’.
- The possibility that the lack of response to the young people was in part a result of discriminatory attitudes towards them.
- A lack of disruption strategies during the early period.
- Evidence of a focus on Performance targets meant that child sexual exploitation was not afforded appropriate priority

6.11.2. The focus of the Police IMR is significantly on the effectiveness or otherwise of the investigation, which eventually became Operation Span and whilst this has identified some important learning and is rightly of major concern, this is not always balanced proportionately with equal reflection on the police role in working as part of the multi-agency partnership. The IMR makes a number of critical comments about multi-agency working, but does not always provide adequate analysis of its own role within that partnership.

6.11.3. Consequently the IMR whilst having considerable strengths also has some gaps in relation to the following areas:

- GMP role in relation to routine multi-agency work with the young people
- 4Detail and analysis regarding its involvement with the young people from a welfare/safeguarding perspective following the commencement of Operation Span
- Consideration of the police role in effective joint working with Children's Social Care (ToR 4(b)

6.11.4. Despite the areas for learning identified, only one recommendation has been made by Greater Manchester Police. That is:

> That the Head of Greater Manchester Police Public Protection Division ensures the continued participation of GMP in Project Phoenix and ensures that all agreed recommendations or directives arising out of the project are implemented by Greater Manchester Police within a realistic time scale.

6.11.5. The Serious Case Review Panel has raised questions about the adequacy of this stand alone recommendation in isolation to address all the concerns raised. It was the panel's view that it is over optimistic to believe that the complex difficulties of responding to CSE can be responded to by one approach. It is accepted that the Police have made a significant commitment to the Sunrise team and investigation of CSE in both Rochdale and across Greater Manchester. However, the Panel was concerned that Project Phoenix is still in the early planning stages, that it may or may not ultimately be adopted and that it does not take into account the particular needs of Rochdale or the local multi-agency arrangements.

6.11.6. Two further recommendations have therefore been made for the Police by this Overview Report:

1. GMP to establish a system which will monitor and review the use of escalation with regard to safeguarding cases, both internally and to the CPS.
2. GMP to commit to developing and maintaining the Sunrise team and to working proactively with RBSCB to ensure a cohesive approach pending any final agreement and implementation of Phoenix within Rochdale.

6.11.7 Following presentation of the Overview Report to the RBSCB on 15

November 2013, the Divisional Commander, GMP Rochdale, has submitted the following additional recommendations :

1. CSE and safeguarding children to remain as a priority for GMP and included in the Rochdale divisional delivery plan to support the PCC Police and Crime Plan.
2. To ensure all staff are trained to a minimum required standard and are aware of local safeguarding board procedures.
3. Provide all new operational staff working in Rochdale with induction training in CSE and multi-agency safeguarding children procedures
4. GMP to commit to developing and maintaining the Sunrise Team and to work proactively with the RBSCB to ensure a cohesive approach pending any final agreement and implementation of Phoenix within Rochdale.
5. GMP to re-emphasis the escalation process for the review and professional challenge of CPS decisions.
6. Ensure all officers investigating CSE within the Sunrise team have suitable accreditation within this specialism including the training and development as child abuse investigators.
7. GMP to ensure that there is a clear structure of supervision and monitoring and quality assurance of CSE investigations.
8. Senior Leadership Team to ensure that roles are understood to deliver the Rochdale multi-agency CSE strategy to prevent, protect and prosecute.
9. To develop and implement a toolkit of CSE prevention and disruption activities which can be monitored, evaluated and shared as best practice to ensure continuous improvement.

6.11.8 The following information has been provided by GMP regarding actions taken as a result of the lessons identified in this Review:

- One of the key issues we have previously encountered was the lack of visibility of CSE within our I.T. systems. We have now upgraded OPUS so that all incidents recorded can have a closing code for CSE and flags have been created for crimes, victims, offenders and intelligence. This will allow us to identify and evaluate large pieces of data thus enabling us to create problem profiles across the force and identify force and divisional needs for resources.
- The need for better training of all police officers and staff was also identified and this is now being implemented across the force, with call takers, crime desks, safer schools partnerships as well as response, Integrated Neighbourhood Policing Teams and the Public Protection Investigation Unit officers receiving training.

This is an ongoing process and we are also working to further develop the current Specialist Child Abuse Investigation Development Programme to include CSE.

- GMP has recognised the benefit of co-located safeguarding teams and are implementing teams across most of the divisions to complement existing units such as Protect (Manchester), Sunrise (Rochdale) and Messenger (Oldham). Several other teams are also in the process of co-locating; the Exit team in Bolton and the Phoenix Team at Tameside.

- A welcome recommendation which is being discussed as part of project Phoenix would be to brand each CSE team as Phoenix to increase awareness to police officers and members of the public who the CSE teams are and what they do. The variety of labels is not conducive to an integrated approach to tackling CSE on a Pan Manchester scale. Different divisional names for CSE teams can paint a confusing picture for officers and members of the public, so a central brand would enhance the joint partnership response in this area.

- The Detective Chief Superintendent of the Public Protection Division is leading these on-going developments, and is working closely with the Office of the Police and Crime Commissioner, which demonstrates the commitment GMP have in addressing the challenges faced by CSE.

6.12 Pennine Acute NHS Hospital's Trust

Pennine Acute NHS Hospital's Trust has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared two authors, a paediatrician who had previously worked for PAHT and the Head of Safeguarding for Pennine Acute. The authors have had no operational responsibility in the case or any direct involvement with The Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Acting Medical Director for Pennine Acute. The countersigner had no direct knowledge or involvement with the services provided to The Young People and their families

6.12.1. Pennine Acute provided hospital health services, including maternity, gynaecology and Accident and Emergency services to all the Young People subject to this review.

6.12.2. It is apparent that although there was evidence of good clinical care in relation to the young people, there were a significant number of occasions when opportunities were missed to intervene with the

young people, for example as a result of repeated presentations at A&E including for self harm and during the night time.

6.12.3. The key learning identified for Pennine Acute is as follows:

- Poor recognition and practice regarding social issues, lack of recognition regarding child protection issues in young people particularly within the acute Accident and Emergency setting.
- Due in part to the high turnover of patients within A&E, professionals may focus only on the immediate issue with which they are presented.
- Poor sharing of information and communication and a lack of escalation when a clear pattern of concerning behaviour became apparent, but also in poor documentation practices. A pattern seen in doctors notes of overestimating how well they communicated information to the receiving doctor.

6.12.4. The **recommendations** for action made by Pennine Acute NHS Hospital's Trust are as follows:

1. Development of documentation proforma and training, prompting assessment of social history.

2. Recognition procedures to be reviewed in A & E, Training and awareness raising within PAHT A/E departments to reinforce responsibilities for 16-18 year olds under the Children Act 1989.5.5.5 No information has been provided regarding any immediate actions taken as a result of the lessons identified in the IMR.

3. Safeguarding education to be designed, developed and piloted that is grounded in non-technical skills and human factors including employment of simulation and observation of error and threshold exercises that are grounded in non-technical skills concepts

6.12.5. Pennine Acute Health Trust has provided the following information in relation to actions already taken arising out of this review.

1. Audit has been completed to provide baseline information re: assessment of social history with particular focus on caring responsibilities. An action plan is being monitored through the Trust Safeguarding children Group. A flow chart has been produced prompting inquiry around assessment of social history to add to the proforma currently present. An audit is planned to assess its use.
2. A baseline audit has been completed that considers specifically issues re: 16 and 17 year olds and the consideration of their vulnerability as children. This is in progress and is not completed as yet. Emphasis to 16 and 17 year olds already given in mandatory training and consent training. Specific work in A&E

setting pending. Second wave of CSE briefings planned for later in the year to include this information.

3. This is a major piece of work which has not yet begun. A meeting is planned with a human factors expert to take this forward. Preliminary discussions have taken place with the skills lab to facilitate this type of training.

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6.13 Pennine Care NHS Foundation Trust

Pennine Care NHS Foundation Trust has provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by the Project Lead for Community Commissioning for Quality and Innovation at Pennine Care NHS Foundation Trust. The author has had no operational responsibility in the case or any direct involvement with the Young People or their families and as such met the criteria for independence.

The Report was countersigned by the Acting Head of Safeguarding Children. The countersigner had no direct knowledge or involvement with the services provided to the Young People or their families.

6.13.1. Pennine Care provided services to all the young people through the Crisis Intervention Team, which provided sexual health advice; School Health; Health Visiting and the Child and Adolescent Mental Health Services (CAMHS).

6.13.2. All the young people had been known to the School Health Service prior to 2007 due to problems with school attendance and behaviour and support relating to sexual health. There is evidence of concerned and persistent response by practitioners within the school health service, but also that at times they struggled to effect change or to engage other services as well as they would have wished.

6.13.3. The Crisis Intervention team had intermittent contact with all the young people during the time frame. The team first had contact with [redacted]

Understanding CIT's role within the multi-agency partnership has proved more difficult. It was suggested by CITC at the Home Affairs select Committee that the team had made over 100 referrals to Children's Social Care or the police and nearly 200 "alerts' regarding these and other young people. This has been considered in more detail in the critical analysis, however the evidence presented to this report is that in relation to these 6 Young People there were a total of 4 referrals to CSC and 2 to Greater Manchester Police during the time period covered by this review.

6.13.4. Pennine Care has openly identified that although the CIT team had begun to recognise CSE before many of the other agencies, there were significant flaws in their understanding of the requirements of safeguarding, their approach to multi-agency working and

information sharing and their willingness to access supervision. As a result the team, whilst having developed a working understanding of CSE did not always contribute well to the multi-agency response and the attempts to safeguard the young people concerned.

6.13.5. Referrals were made to CAMHS for [redacted] in 2009; [redacted] in 2005 and again in 2008; [redacted] in 2011 and [redacted] in 2008. Information from

6.13.6. Health Visiting services were involved with the children of all the young people except [redacted] who did not have children.

6.13.7. The analysis of Pennine Care's involvement is of a good quality and care has been taken to achieve a more nuanced understanding of practice leading to a good depth of learning.

6.13.8. The **recommendations** for action for Pennine Care NHS Foundation Trust are as follows:

1. CAMHS to review DNA policy in collaboration with key referrers in order to promote positive engagement of potential service users.

2. Crisis Intervention Team: Improvement in safeguarding children practice. All CIT staff to attend Level 3 Safeguarding children training.

3. The Crisis Intervention Team to undertake training in relation to record keeping requirements in respect of safeguarding children and statutory/legal responsibilities.

4. The Crisis Intervention Team, Health Visiting and Safeguarding Children Teams records should comply with record keeping practice in relation to safeguarding children and/or legal/statutory requirements.

5. Structured safeguarding supervision to be implemented within the Crisis Intervention Team.

6. Crisis Intervention Team to be made aware of role and responsibilities of other key children's services professionals (i.e. HV and SHP) in that they work with.

7. Exploration work with individual practitioners within the Crisis Intervention Team and the team to determine methods of 'positive' engagement of subjects involved or vulnerable to CSE.

8. Role of the School Health Practitioner in relation to the contribution to safeguarding children is reviewed.

9. Improve interview skills and techniques for School Health Practitioners involved with victims involved in, or vulnerable to, CSE.

10. Review the effectiveness of the Safeguarding Children Policy.

11. Lessons Learned from the IMR shared with services involved.

6.13.9. Pennine Care have provided the following information regarding actions that have already taken place as a result of this review:

1. All CIT staff have received Level 3 Safeguarding Children Training
2. Record keeping training for CIT staff has been organised and will be delivered by December 2013
3. A record keeping audit of CIT, HV and SHP records has been completed
4. A record keeping audit of CIT records in relation to safeguarding processes is planned for October 2013
5. Structured safeguarding supervision has been implemented within the CIT. A variety of approaches ranging from 1-1 and group supervision is now undertaken
6. School Health Practitioner Safeguarding Pathway is currently under development

6.14 RMBC Homelessness Service/Rochdale Boroughwide Housing

Housing Services Rochdale (encompassing two services: RMBC Homelessness Service & Rochdale Boroughwide Housing) has provided a chronology and Individual Management Review for this Serious Case Review.

The report has been prepared by the Director of Services for Neighbourhoods. The author has had no operational responsibility in the case or any direct involvement with The Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Chief Executive who had no direct knowledge or involvement of the services provided to The Young People and their families.

6.14.1. Homelessness/RBH had contact with all 6 of the young people as well as some of their wider family members, generally as a result of seeking accommodation through the homelessness service. Various offers of accommodation were made to the young people at different times including through the emergency service, supported housing and independent tenancies.

6.14.2. Both services have acknowledged that its staff had comparatively little knowledge of Child Sexual Exploitation in the early years covered by this review and identified how this is being resolved. It has also identified a gap in the quality of its partnership working with CSE.

6.14.3. Whilst both services have identified learning from this review and used the opportunity to consider further improvements, none of the identified weaknesses in policy and practice had a significant impact on the protection of these young people

6.14.4. The **recommendations** for action for Housing Services Rochdale are as follows:

1. Establish protocol for dealing with applications from self referring applicants where safeguarding/sexual exploitation issues are presented.

2. Look to allocate Assessment Officers cases so that continuity is maximised. Consider risk Assessing culturally appropriate case distribution.

3. Consider MAPPA style approach to rehousing victims/perpetrators of sexual exploitation

4. Improve relationship with CSC

5. Review how Homelessness Service assesses vulnerability.

6.14.6 The following information has been provided by Housing Services Rochdale regarding immediate actions taken as a result of the lessons identified in the IMR:

1. Recommendation that the allocation of cases to Assessment Officers when homelessness presentations are made, should try to ensure continuity, so that presenting households are 'followed through' wherever possible. The Homelessness Manager is trying to co-ordinate this via one to one supervisory meetings and amendments to work practices.

2 The Service Manager has met the YOT Manager who has oversight of those 16/17yr olds referrals presenting from Children's Services. They have agreed to support the development of an Access service based at their office. This has also been agreed as part of Homelessness Strategy Action plan and will be monitored as a specific action.

3. RBH's Director of Services for Neighbourhoods has contacted the new lead officer in CSC, with a view to establishing more regular contact at an operational level, to consider how applications for housing from individuals involved either as victims or perpetrators of CSE and child abuse should be dealt with, and to improve relations generally**.**

6.15 Schools

RMBC Support for Learning Service have provided a chronology and Individual Management Review on behalf of Schools for this Serious Case Review. The report has been prepared by a Senior Education Welfare Officer. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence. The Report was countersigned by the Senior

School Improvement Manager who had no direct knowledge or involvement of the services provided to The Young People and their families.

6.15.1. Five of the 6 young people attended schools within the Borough during the time period subject to this review. [redacted] had left SchoolB by the beginning of the time period. SchoolA and SchoolB closed during the time period and failed to archive their files correctly leading in the loss of all of the school files for [redacted] and some of the files in relation to [redacted]. A comprehensive search for these files was undertaken by the IMR author.

6.15.2. Whilst in the early period it is apparent that school staff had little understanding of CSE, it is equally evident that they recognised that the young people had significant welfare and safeguarding needs and attempted to pursue these. Schools made a number of attempts to refer the young people both to CSC and on to other support services with mixed success. Staff lacked confidence in challenging decisions made by CSC and there was no formal escalation process undertaken at these points.

6.15.3. The schools IMR has clearly identified gaps in practice and areas for learning responding with relevant recommendations.

6.15.4. The recommendations for action for Schools are as follows:

1. Staff in schools need to use the local policies and procedures to challenge decisions made where there are clear differences of opinion in safeguarding concerns and ensure that actions, outcomes and follow up around safeguarding concerns is a priority. The process by which concerns are escalated needs to be clear and concise and shared with schools. (Schools and safeguarding board).

2. Early intervention and other support services are flexible in their approach of where their service can best be delivered to young people taking their needs into consideration. Given that school staff see young people more than any other service, especially if that pupil is on roll and attending well, then the good practice model of services going to the young person should be considered. (Safeguarding Board).

3. The Common Assessment Framework tool needs to be more widely used in schools to address early signs of concerns and vulnerability and that further training, advice and support is made available to education settings in order to fully utilise this early assessment tool.

4. Schools to be issued with new protocols and training as to the expected educational recording standards for pupil files and that this practice is standardised across all schools in the borough.

5. Further analysis of staff understanding and information sharing around CSE will need to be monitored in the future. It will be a long term action to establish CSE within both primary and secondary school curriculum although training on this has already taken place both for designated safeguarding leads and PSHE co-ordinators in schools.
6. A new policy needs to be developed on the archiving of pupil school files which includes timescales for the destruction of pupil education and child protection files. I would appear that there is currently no policy in place advising schools about requirements.
7. With the increasing autonomy of schools there needs to be better links forged between school representation on the LSCB, ensuring that key safeguarding themes, SCR lessons and other relevant safeguarding information is brought directly to the attention of schools.

6.15.5. The following information has been provided by regarding actions already taken as a result of the lessons identified in the IMR

1. Education Safeguarding Lead has met with the council's corporate Customer and ICT services records manager to look at a secure way of indexing and archiving school files in the future. Currently working on making the corporate council policy available to educational establishments and issuing schools with a separate addendum to the corporate procedures to ensure that all school files are, in future archived with Safe Records Management so that school files can be located and tracked when requested.
2. Meeting organised with the e-CAF co-ordinator for early in the Autumn Term 2013 and plans to re-instate the Schools' Safeguarding leader Network meetings to ensure that learning points from SCRs are embedded in schools and to look at topical local and national issues, including the use of CAF as an early intervention assessment tool.
3. Education Safeguarding Officer is currently looking at tackling this issue at the first Safeguarding Leaders network meeting to be held in the Autumn term by consulting with and using a combination of best practice from a range of schools
4. All school Safeguarding leads have attended a ½ day 'train the trainers' session on CSE for them to roll out across the different staffing groups in the school setting. These sessions took place over the Autumn and Spring Term 2012/13 and were delivered by the Education Safeguarding Lead and the Healthy Schools Programme Manager
5. All the school's PSHE co-ordinators have attended a session delivered by the Healthy Schools Programme Manager on embedding CSE which is age and stage appropriate into the curriculum. All training returns received by Healthy Schools programme Manager, report written and forwarded on to the

Assistant Director, Early help and Schools and the Safeguarding Board multi agency trainer who is collating evidence on the embedding CSE within the curriculum.

6.16 Youth Service

Rochdale Borough Youth Service have provided a chronology and Individual Management Review for this Serious Case Review. The report has been prepared by a Senior Youth Officer. The author has had no operational responsibility in the case or any direct involvement with The Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Head of Schools Service who had no direct knowledge or involvement of the services provided to The Young People and their families.

6.16.1. The Youth Service had some very limited contact with [redacted] These 5 young people all attended open access youth provision, but did not have any individual sessions with staff. The young people's attendance varied between 13 sessions and 1 session and took place at their local Youth Centre. Given the nature of the provision there was no reason for the Youth Service to have specific knowledge about any of the young people, including whether they were victims of CSE.

6.16.2. Despite their limited involvement, the Youth Service have taken the opportunity as a result of being part of this Review to reflect on their service and in particular to consider how they can improve their understanding of sexual exploitation and their services to young people who might be at risk.

6.16.3. The **recommendations** for action for Rochdale Youth Service are as follows:

1. Continue to deliver and improve training to all staff
2. Improving information and support to young people
3. Developing the recording of individual concerns by generic practitioners
4. Improving information sharing and communication particularly between generic and targeted teams
5. To develop and improve the effectiveness of gender specific work in universal provision.

6.16.4. The Youth Service has provided the following information regarding actions already taken arising out of this Review:

1 General Safeguarding and CSE courses and briefings are planned and have been delivered to staff and volunteers.

2. The Senior Management Team have requested that appropriate sessions are delivered as a planned part of youth work programmes . These will be checked and monitored.
3. An incident report form has been developed and will be fully embedded in September
4. Work is underway to devise a process and a means of recording improved information sharing.
5 The Senior Management Team have requested that gender specific sessions are delivered as a planned part of youth work programmes . These will be checked and monitored.

6.17 Youth Offending Team (YOT)

Rochdale Youth Offending Team have provided a chronology and Individual Management Review for this Serious Case Review.The report has been prepared by the Deputy Manager. The author has had no operational responsibility in the case or any direct involvement with the Young People and their families and as such met the criteria for independence.

The Report was countersigned by the Service Manager. The Service Manager was responsible for managing the YOT service and directly responsible for supervising the operational managers. There is therefore some compromise to the independence of the oversight of this IMR.

6.17.1. The YOT team had some limited knowledge of [redacted] having been routinely informed by the police when they committed minor offences, but with direct contact with these two young people. [redacted], [redacted] all received statutory orders as a result of offending and were Case Managed by the YOT team. [redacted] was involved with the YOT between 2005 and 2007 having been made subject to a 3 month referral order and 2 Reparation Orders. . [redacted] was known to the YOT as a result of a short period of bail support and a three month Referral order during 2006. [redacted] undertook a Final Warning Programme in 2008 and a period of prevention work in 2008 followed by a 6 month Referral Order and a Reparation Order which she completed in Spring 2010.

6.17.2. The YOT team had no knowledge about CSE in relation [redacted] until March 2006 and there is an acknowledgement that in relation to [redacted] work took place in isolation of other agencies . There is no information as to how the information in 2006, which in fact was about [redacted] effected the work that was undertaken with her. Information about [redacted] being a victim of CSE was known from the outset of the YOT involvement as she was at the time subject to a CP Plan. The YOT is critical of others failure to share information

6.17.3. The YOT has shown that it met its statutory obligations and also provided extra services to support some of the young people, for example in relation to diversionary activities. It has acknowledged problems with managerial oversight and supervision including a lack

of clarity as to who was responsible for the supervision of one worker and in relation to a social work student who was case managing [redacted] as well as inconsistency in assessing risk of vulnerability.

6.17.4. Whilst YOT has identified learning from this Review, the information and analysis would at times have benefitted from a greater degree of precision and detail at times, combined with a more self critical approach. This could have led to more thorough understanding of the practice and what could be learnt from it. For example it is of interest that despite their involvement with [redacted] the YOT were not able to identify any information about her parents, even though one of the workers had regular contact with [redacted]. It is also stated that YOT had no knowledge of [redacted] experiencing CSE, yet their own records state that this information was shared with [redacted]'s worker.

6.17.5. Recommendations whilst not without merit would benefit from more considered thought. For example it has been identified that inconsistency in workers was unhelpful and yet the recommendation is simply to review the effectiveness of multiple workers. Given that the IMR refers to the fact that this led to a recommendation from a previous Serious Case Review, an approach of simply looking at the issue again appears weak. There is a risk for the YOT that as a result there are gaps in their learning from this review and that this has not been addressed despite repeated feedback during the SCR process from panel members and as such could appear a little complacent.

6.17.6. The **recommendations** for action for the Youth Offending Team are as follows:

1. Re-establish the YOT sexual exploitation group, to link with Sunrise, to monitor screening of CSE ,referrals to CSC and follow up work
2. Review Case Planning Forum process in relation to CSE
3. Establish the Case Planning Forum action tracker
4. Review effectiveness of multiple workers working with young people
5. Review YOT's use of the CSE screening tool
6. Establish more consistency in quality and frequency of supervision
7. Improve YOT's links to strategic plans
8. Ensure YOT plans (PTGS and Vulnerability Management Plans) highlight staying safe work

6.17.7. The Youth Offending Team provided the following information in relation to actions already taken arising out of this review:

- The YOT have a nominated social worker as a virtual member of the Sunrise team.

- All young people subject to YOT interventions have a CSE screening tool completed. This is monitored through the intervention check process and through reviews which are conducted in accordance with National Standards. All YOT staff have attendance CSE training and YOT senior staff have contributed to it's development and delivery.

- A YOT deputy manager is leading a task and finish group looking at peer on peer abuse and will report back to the safeguarding board.

- HMIP has made comment following the full joint inspection carried out in July 2013, that there where were clear protocols in place for thresholds relating to child protection and that good communication had been established between the YOT and sunrise.

6.18 Heywood, Middleton and Rochdale clinical commissioning group

The Primary Care Trust responsible for commissioning has provided a Health Overview Report encompassing the three individual IMRs. The report has been prepared by the Designated Nurse for Safeguarding Children and Adults. The author has had no operational responsibility in the case or any direct involvement with the Young People and as such met the criteria for independence. The report was signed by the Executive Board Nurse. The countersigner had no direct knowledge or involvement with the services provided to the Young People or their families.
The Health Overview Report has made one additional recommendation for action for health commissioners
In conjunction with Public Health and health commissioners review health services which provide sexual health services to young people, consider the extent to which safeguarding and child protection are considered as part of sexual health assessments.

Name of SCRP chair assuring quality of overview report	Audrey Williamson
Date	12th November 2013

1 Endorsement by LSCB

Name of LSCB Chair	Jane Booth
Date of LSCB endorsement of overview report	15th November 2013

Signed on behalf of LSCB:

Position: Independent Chair of Rochdale SCB

Author: Sian Griffiths

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Appendix A: Terms of Reference

Appendix B: Full Glossary of Codes for Professionals and Family Members

Appendix C: Comprehensive Chronology

Appendix D: Explanation of processes referred to

APPENDIX D: Explanations of terms referred to in the Overview Report

A **Strategy Meeting/Discussion** is required whenever there is reasonable cause to suspect that a child is suffering, or likely to suffer significant harm. This should include CSC, the police, health and any other appropriate body. The meeting should agree on further actions required, for example legal action or further enquiries under the Children Act 1989.

An **Initial Assessment** is a brief assessment undertaken by CSC following any referral where it is necessary to identify if a child is in need or suffering/likely to suffer significant harm as defined in statutory guidance (Working Together).

A **Core Assessment** under S47 of the Children Act 1989 is a detailed assessment undertaken by CSC when it is suspected that a child is suffering, or likely to suffer, significant harm.

Section 20 of the Children's Act: provision for a child in need to be accommodated by the Local Authority with the consent of the parents or others with parental responsibility.

An **Emergency Protection Order** is a short term order made by the courts when a child requires urgent protection either to remove a child to a safe place or to prevent them being removed from a safe place.

Looked After Child (LAC) Reviews: statutory reviews of plan for children who are looked after by the local authority

The **Core Group** is the group of family members and key professionals who meet regularly to implement and review the Child Protection Plan

Gateway or Legal planning meetings are held when a social worker and manager decide that the circumstances of a child require detailed consideration with legal services and there is a strong prospect that the council is likely to need to seek an application to court for an order.

A **Referral Order** (Criminal Evidence Act 1999) is a court order lasting between 3 months and 12 months during which the young person undertakes reparation work with the victim or community and also an offending behaviour programme.

A **Reparation Order** is a court order which requires the young person to complete a set number of hours undertaking either direct or indirect reparation work.

ASSET is an assessment tool used nationally by YOT to assess risk of reoffending, vulnerability and risk of serious harm

Achieving Best Evidence: Guidance produced by government regarding video-recorded interviews with vulnerable, intimidated and significant witnesses. (2nd Edition, 2007)

School Action is a plan of educational support put in place when there is evidence that a child is not making progress at school and there is a need for action to be taken to meet learning difficulties. **School Action Plus** is adopted when adequate support is not being achieved by School Action and there is a need for more specialist help

LEARNING DISABILITY, LEARNING DIFFICULTIES AND SPECIAL EDUCATIONAL NEEDS

Learning disability is the term used by the Department of Health within their policy and practice documents.

Valuing People (2001) describes a 'learning disability' as a:

- significantly reduced ability to understand new or complex information, to learn new skills
- reduced ability to cope independently which starts before adulthood with lasting effects on development.

(Department of Health. Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001).

Learning difficulty is a term used to describe any one of a number of barriers to learning that a child may experience. It is a broad term that covers a wide range of needs and problems, including dyslexia and behavioural problems, and the full range of ability.

Special Educational Needs: The 1996 Education Act defines a child as having Special Educational Needs "if they have a learning difficulty which calls for special educational provision to be made for them". Children have a learning difficulty if they:

a. have a significantly greater difficulty in learning than the majority of children of the same age; **OR**
b. have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local authority; **OR**
c. are under compulsory school age and fall within the definition at a. or b. above or would do so if special educational provision was not made for them.